

BEHAVIORAL HEALTH OUTPATIENT PRIOR AUTHORIZATION FAX FORM

Request for additional units. Existing Authorization Units
 Standard Request - Determination within 14 working days of receiving all necessary information
 Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness, or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Date of Birth *
 (MMDDYYYY)
 Member ID/Medicaid ID * Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI * Requesting TIN * Requesting Provider Contact Name
 Requesting Provider Name * Phone * Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider
 Servicing NPI * Servicing TIN * Servicing Provider Contact Name
 Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

Primary Procedure Code *
 (CPT/HCPCS) (Modifier)
Additional Procedure Code
 (CPT/HCPCS) (Modifier)
Start Date OR Admission Date*
 (MMDDYYYY)
Diagnosis Code*
 (ICD-9/ICD-10)
Additional Procedure Code
 (CPT/HCPCS) (Modifier)
Additional Procedure Code
 (CPT/HCPCS) (Modifier)
End Date OR Discharge Date
 (MMDDYYYY)
Total Units/Visits/Days

OUTPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes)

- 270 Psychiatric Evaluations
- 250 Outpatient Therapy
- 185 Community Based Services
- 195 Crisis Psychotherapy
- 160 Electroconvulsive Therapy
- 265 Psych Testing

Additional Diagnosis Code
 (ICD-10)
Additional Diagnosis Code
 (ICD-10)
Additional Diagnosis Code
 (ICD-10)

**ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.**

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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