Outpatient Medicaid Authorization Request Form

To submit PA electronically access the portal at countycare.valence.care
Fax completed form to: 1-866-209-3703
Phone number: 1-855-444-1661

* = Required Information

*Requestor's Contact Name: ***Requestor's Contact Number:**

PATIENT INFORMATION

*Member Name:	*Date of Birth:
*Member ID Number:	Member Phone Number:

*Service is:
- ☐ Elective/ Routine
- ☐ Expedited/ Urgent   *Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.*
- ☐ Extension to Authorization _____
- ☐ Continuity of Care

SERVICE TYPE

☐ Office Visit / Specialty Consult	☐ Genetic Testing / Counseling	☐ Outpatient Hospice	☐ Pulmonary Rehab
☐ Cochlear Implants / Surgery	☐ Drug Testing	☐ Home Health	☐ Prosthetics
☐ Pain Management	☐ MRI/MRA/Pet Scan	☐ Physical Therapy	☐ Orthotics
☐ Chiropractic	☐ CT Scan	☐ Occupational Therapy	☐ Oxygen Equipment/ Gas Supply
☐ Biopharmacy	☐ OB Ultrasounds	☐ Speech Therapy	☐ DME Rental
☐ Outpatient Surgery	☐ Transplant Evaluation / Work-up	☐ Cardiac Rehab	☐ DME Purchase $_____

PROCEDURE INFORMATION

*ICD-10 Diagnosis: Diagnosis Description:

*CPT Code: _____   Units: _____   CPT Code: _____   Units: _____   CPT Code: _____   Units: _____

CPT Code: _____   Units: _____   CPT Code: _____   Units: _____   CPT Code: _____   Units: _____

* Date(s) of Service:

PROVIDER INFORMATION

Ordering Provider: ☐ *Primary Care Physician*

*Name: _____	*NPI: _____	TIN: _____
*Fax: _____	Phone _____	
*Address:		

Servicing Provider: ☐ *Same as Ordering*   *Same as Facility*

*Name: _____	*NPI: _____	*TIN: _____
*Fax: _____	Phone _____	
*Address:		

Facility: ☐ *N/A*

*Name: _____	*NPI: _____	*TIN: _____
*Fax: _____	Phone _____	
*Address:		

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

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