



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: <input type="checkbox"/> Elective/ Routine <input type="checkbox"/> Expedited/ Urgent <i>Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.</i> <input type="checkbox"/> Extension to Authorization _____ <input type="checkbox"/> Continuity of Care	

SERVICE TYPE

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

PROCEDURE INFORMATION

*ICD-10 Diagnosis: _____	Diagnosis Description: _____
*CPT Code: _____ Units: _____	CPT Code: _____ Units: _____
CPT Code: _____ Units: _____	CPT Code: _____ Units: _____

*** Date(s) of Service:** _____

PROVIDER INFORMATION

Ordering Provider:	<input type="checkbox"/> <i>Primary Care Physician</i>
*Name: _____	*NPI: _____ TIN: _____
*Fax: _____	Phone _____
*Address: _____	
Servicing Provider:	<input type="checkbox"/> <i>Same as Ordering</i> <i>Same as Facility</i>
*Name: _____	*NPI: _____ *TIN: _____
*Fax: _____	Phone _____
*Address: _____	
Facility:	<input type="checkbox"/> <i>N/A</i>
*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**

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.
Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.