



Outpatient Medicaid Authorization Request Form

Visit the provider portal to submit initial authorization requests online at <https://www.myidentifi.com>

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: _____
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.

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