CountyCare HEALTH PLAN

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:
- ☐ 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