SUPERIOR HEALTHPLAN STAR+PLUS MEDICARE-MEDICAID PLAN (MMP) OUTPATIENT AUTHORIZATION FORM

allwell. FROM superior healthplan

All Part B Drug Requests: **Fax** 844-960-1785
Standard Requests: **Fax** to 877-808-9368
Incontinence Supplies **Fax** 800-690-7030
Behavioral Health Requests/Medical Records: **Fax** 855-772-7079
Transplant: **Fax** 833-589-1243

☐ Request for additional units. Existing Authorization _____ Units _____

For All Standard or Expediated Part B Drug Requests, please fax to 844-960-1785.

For Standard requests, complete this form and FAX to the appropriate department. Determination made as expeditiously as the enrollee's health condition requires, but no later than **3** business days after receipt of request.

For Expedited requests, please CALL 800-218-7508. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID*

Last Name, First *

Date of Birth* (MMDDYYYY)

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

If this request is for a Part B DRUG, please fax to 844-960-1785.

Primary Procedure Code* (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date* (MMDDYYYY)

Diagnosis Code* (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)* ☐☐☐

199 Adult Day Care
207 Adult Foster Care
904 Nursing Facility (Residential/Custodial Care)
422 Biopharmacy (please fax to 844-960-1785)
401 Cardiac/Pulmonary Rehab
682 Community Transition
198 CFC Emergency Response
299 Drug Testing
725 Emergency Response-Installation
340 Emergency Response-Monthly Rental
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
755 Habilitation
756 CFC Habilitation
249 Home health
657 Home Health Waiver
225 Home Meals
104 Home Modifications
290 Hyperbaric Oxygen Therapy
390 Hospice Services
141 Imaging
729 Neuropsychological Testing
112 Nutritional Supplements and/or Services
211 OB Ultrasound
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
470 Personal Care Worker Services
650 Radiation Therapy
421 Respite Services
201 Sleep Study
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
209 Transplant Surgery
993 Transplant Evaluation
724 Transportation

DME

417 Rental
120 Purchase _____ (Purchase Price)

Behavioral Health

510 BH Medical Management
530 BH PHP
512 BH Community Based Services
514 BH Day Treatment
515 BH Electroconvulsive Therapy
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

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.

Rev 04 02 2021
TX-PAF-0907