superior healthplan Advantage

OUTPATIENT MEDICARE AUTHORIZATION FORM

Complete and Fax to: 1-877-808-9368

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ Standard Request - Determination within 14 days from receipt of all necessary information.

☐ Expedited Request - By signing below, I certify that applying the 14 day timeframe could seriously jeopardize the member's health, life, or ability to regain maximum function.

EXPEDITED REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY. X

**** INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Date of Birth * (MMDDYYYY)

Member ID *

Last Name, First

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

ICD-9 ☐ ICD-10 ☐

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

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-9/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)

Code	Service
422	Biopharmacy
	DME (Orthotics and Prosthetics)
417	Rental
120	Purchase $ (Purchase Price)
299	Drug Testing
709	Genetic Testing
249	Home Health
729	Neuropsych Testing
410	Observation (only > 24hrs)
794	Outpatient Services
171	Outpatient Surgery
997	Office Visit/Consult (non par only)
202	Pain Management
420	Pulmonary Rehab
201	Sleep Study
	Therapy
790	Occupational
101	Physical
701	Speech
617	Non-Emergent Medical Transportation-Ambulance Only

Outpatient Services Examples:
- **Skin Debridement/Wound Care**
- **Hyperbaric Oxygen Therapy**

Home Health Examples:
- **Skilled Nursing Visits**
- **Home Health Aid**
- **Home Therapy (PT,OT,ST)**

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.

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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