



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

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

Incontinence Supplies Fax:
1-800-690-7030

Request for additional units. Existing Authorization Units

STANDARD: Standard authorization decisions will be made no later than 3 business days after receipt of the request for service.

EXPEDITED: Expedited service authorizations decisions will be made no later than one business day after the receipt of the request for service.

EXPEDITED REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN.

* 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 As of 10/01/2015, only ICD-10 codes are accepted.

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)

- 422 Biopharmacy
- 401 Cardiac Pulmonary Rehab

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 > 48 hrs)

- 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

- 650 Radiation Therapy
- 617 Non-Emergent Medical Transportation-Ambulance Only
- 290 Hyperbaric Oxygen Therapy

Outpatient Services Example:
- Skin Debridement/Wound Care

Home Health Examples:
- Skilled Nursing Visits
- Home Health Aid

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.

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.

