MEDICAID
PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records:
Fax 866-570-7517

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

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 3 calendar days to avoid complications and unnecessary suffering or severe pain.

Urgent requests must be signed by the requesting physician to receive priority.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Medicaid/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

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

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

***Start Date** ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Diagnosis Code ☐☐☐.☐☐☐☐ (ICD-10)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

End Date ☐☐☐☐☐☐☐☐ (MMDDYYYY)

Total Units/Visits/Days ☐☐☐☐

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) ☐☐☐

☐ Check Box for Inpatient Elective Service

422 Biopharmacy
401 Cardiac/Pulmonary Rehab
299 Drug Testing
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
997 Office Visit/Consult
794 Outpatient Services
101 Physical Therapy
790 Occupational Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

BEHAVIORAL HEALTH
510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
517 BH Medication Check
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME
417 Rental
120 Purchase ☐☐☐☐☐☐☐☐ (Purchase Price)

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. 06 25 2020
TX-PAF 5869