OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 1-800-690-7030
Behavioral Health Requests/Medical Records:866-570-7517
Transplant Request **Fax** to: 833-589-1245

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

☐ **Non-Urgent Request**

☐ **Urgent Request -** For life-threatening condition, hospitalized member, treatment after stabilizing an emergency condition. Reason for urgency must be indicated to process as urgent.

Required Field for URGENT REQUESTS: Reason for urgency must be indicated to process as urgent

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First Name

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ Same as Requesting Provider (Please include servicing provider address if servicing provider is the same as requesting provider.)

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

*Servicing Provider Address

*City

*State

*Zip

AUTHORIZATION REQUEST

*Primary Diagnosis Code (ICD-10)

Place of Service Codes Full List: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

***Primary** Procedure Code		***Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	*Place Of Service Code
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)	(MMDDYYYY)		
Additional Procedure Code		**Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	Place Of Service Code
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)	(MMDDYYYY)		
Additional Procedure Code		**Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	Place Of Service Code
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)	(MMDDYYYY)		
Additional Procedure Code		**Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	Place Of Service Code
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)	(MMDDYYYY)		

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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Rev. 04 01 2026
TX-PAF-5869