



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

Standard Requests: **Fax** to 1-877-808-9368
Part B Drug request: **Fax** to 1-844-960-1785
Incontinence Supplies: **Fax** 1-800-690-7030
Behavioral Health Requests/Medical Records: **Fax**
1-855-772-7079

Request for additional units. Existing Authorization

Units

For Standard requests, complete this form and FAX to 1-877-808-9368. 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 1-800-218-7508. 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.

For Part B Drug requests, complete this form and FAX to 1-844-960-1785.

*** 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

Primary Procedure Code*	Additional Procedure Code	Start Date OR Admission Date*	Diagnosis Code*
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)
Additional Procedure Code	Additional Procedure Code	End Date OR Discharge Date	Total Units/Visits/Days
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	

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 1-844-960-1785) 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
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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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