

Request for additional units. Existing Authorization  Units

Standard Request - Determination within 15 calendar days of receiving all necessary information.

Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours 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

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 * <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	Additional Procedure Code <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	Start Date OR Admission Date * <input type="text"/> (MMDDYYYY)	Diagnosis Code * <input type="text"/> (ICD-10)
Additional Procedure Code <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	Additional Procedure Code <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>

### OUTPATIENT SERVICE TYPE \* (Enter the Service type number in the boxes)

412 Auditory Services	299 Drug Testing	210 Orthotics
422 Biopharmacy	709 Genetic Testing	927 Outpatient Hospice
712 Cochlear Implants and Surgery	249 Home Health	794 Outpatient Services
<b>Dental Anesthesia</b>	240 Inpatient Hospice	171 Outpatient Surgery
911 Office Visit	290 Hyperbaric Oxygen Therapy	202 Pain Management
721 Other Site	211 OB Ultrasound(s)	147 Prosthetics
<b>DME</b>	497 Office Visit/Specialty Consult	201 Sleep Study
417 Rental		724 Transportation
120 Purchase <input type="text"/>		
(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.**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.  
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