

Outpatient Authorization Form Continued



This page is optional and meant to be used when a request exceeds more than four (4) Procedure Codes.

* Indicates Required Field

▶ Member Information

* Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First

▶ Authorization Request

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

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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