

OUTPATIENT MEDICAID

PRIOR AUTHORIZATION FORM

Request for additional units. Existing Authorization Units

Mark Standard or Urgent Request if initial request

Standard requests - Determination within 14 calendar days from receipt of all necessary information.

Urgent requests - Expedited request necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function. Authorization decision will be done within **72** hours of receipt of request. **42 CFR §438.210**

Iowa Total Care
 Wellpoint
 Molina Healthcare
 Fee for Service

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Medicaid ID*
 Last Name, First
 Date of Birth* (MMDDYYYY)

REQUESTING PROVIDER INFORMATION *Address Required on Supplemental Form*

Requesting NPI*
 Requesting TIN*
 Requesting Provider Contact Name

Requesting Provider Name
 Phone
 Fax*

SERVICING PROVIDER / FACILITY INFORMATION *Address Required on Supplemental Form*

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)

*Primary Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	*Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	*Place Of Service Code <input type="text"/>
Additional Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	Place Of Service Code <input type="text"/>
Additional Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	Place Of Service Code <input type="text"/>
Additional Procedure Code <input type="text"/> (CPT/HCPCS)	(Modifier) <input type="text"/>	Start Date OR Admission Date <input type="text"/> (MMDDYYYY)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>	Place Of Service Code <input type="text"/>

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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