LOUISIANA HEALTHCARE CONNECTIONS

OUTPATIENT
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-877-401-8175

○ Standard Request - Determination within 14 working days of receiving all necessary information

○ Urgent Request - By checking this box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (not life threatening) which must be treated within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ ALL URGENT REQUESTS **MUST BE SIGNED BY THE REQUESTING PHYSICIAN** IN ORDER TO BE PROCESSED AS AN URGENT REQUEST.

***INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID * (Medicaid/Medicare)

Date of Request * (MMDDYYYY)

Date of Birth * (MMDDYYYY)

Last Name, First

Primary Diagnosis * (ICD-9) (Description)

Additional Diagnosis (ICD-9) (Description)

REQUESTING PROVIDER INFORMATION

Provider NPI * (National Provider Identifier)

Provider TIN *

Provider Name

Provider Contact Name

Provider Phone

Provider Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ○ *The Servicing Provider / Facility is the same as Requesting Provider - information below will be populated using the Requesting Provider values above*

Servicing NPI *

Servicing TIN *

Servicing Provider / Facility Name

Authorization Specific Contact Name

Servicing Phone

Servicing Fax

AUTHORIZATION REQUEST

Primary Procedure Code * (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

(Procedure Code Description)

Requested **Start Date *OR* Admission Date** * (MMDDYYYY)

Requested **End Date *OR* Discharge Date** * (MMDDYYYY)

Total Units/Visits/Days *

OUTPATIENT SERVICE TYPE * *(Fill in only 1 Circle)*

- ○ Auditory
- ○ Biopharmacy
- Chiropractor
  - ○ *Office Visit*
  - ○ *Other Site*
- ○ Cochlear Implants & Surgery
- ○ DME
- ○ Genetic Testing & Counseling
- ○ Home Health
- ○ Hospice Outpatient
- ○ Medical/Food Thickener
- ○ Neuropsych Testing
- ○ Nutritional Supplements & Services
- ○ OB Ultrasound
- ○ Observation (required after first 30 hours)
- Office Visit / Consult
  - ○ *Office Visit*
  - ○ *Other Site*
- ○ Orthotics
- ○ Outpatient Services
- ○ Outpatient Surgery
- ○ Pain Management
- ○ Parenteral/Enteral Feedings
- ○ Prosthetics
- ○ Sleep Study
- ○ Stereotactic Radiosurgery
- ○ Transport

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.