



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.

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 *

Last Name, First

(MMDDYYYY)

Primary Diagnosis *

(ICD-9)

Additional Diagnosis

(ICD-9)

REQUESTING PROVIDER INFORMATION

Provider NPI * (National Provider Identifier)

Provider TIN *

(Description)

(Description)

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)

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

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

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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