OUTPATIENT MEDICAID
PRIOR AUTHORIZATION FORM

Amerigroup | iowa total care | ia health link | Hawki | IOWA Department of HUMAN SERVICES

☐ 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 §438.21**

5879

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Date of Birth* ☐☐☐☐☐☐☐☐ (MMDDYYYY)

Medicaid/Member ID* ☐☐☐☐☐☐☐☐☐☐

Last Name, First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 ☐☐☐☐☐☐☐☐☐☐

AUTHORIZATION REQUEST

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

☐ Additional codes will be provided on Supplemental Information Form

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

*Diagnosis Code ☐☐☐.☐☐☐ (ICD-10)

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

Total Units/Visits/Days For Primary CPT Code ☐☐☐☐

Amerigroup Iowa, Inc.

Physical Health - Fax #: 800-964-3627

- ☐ Other Oxygen Services
- ☐ Biopharmacy
- ☐ Drug Testing
- ☐ Genetic Testing & Counseling
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Hospice
- ☐ Office Visit/Consult
- ☐ Outpatient Services
- ☐ Outpatient Surgery
- ☐ Transplant Therapy
- ☐ Neurobehavioral Rehabilitation Services(CNRS)
- ☐ Home Health

DME

- ☐ 417 Rental
- ☐ 120 Purchase ☐☐☐☐☐ (Purchase Price)

Behavioral Health - Fax #: 1-844-451-2826

- ☐ BH Assertive Community Service (ACT)
- ☐ BH Intervention Services (BHIS)
- ☐ BH Community Crisis Services
- ☐ BH Children's Mental Health Waiver (CMHW)
- ☐ BH ABA Services
- ☐ Other BH Outpatient Services

Iowa Total Care

☐☐☐ (Enter the Service type number in the boxes)

Physical Health - Fax #: 833-257-8327

422 Biopharmacy
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
201 Sleep Study
472 Stereotactic Radiosurgery
209 Transplant Surgery
993 Transplant Evaluation
724 Transportation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy

Behavioral Health - Fax #: 844-908-1170

161 BH ABA Services
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intenstive Outpatient Therapy
519 BH Outpatient Therapy
521 BH Psychological Testing

DME

417 Rental
120 Purchase ☐☐☐☐☐ (Purchase Price)

☐ **Please mark if including clinical information with the request**

Fee for Service: Fax # 515-725-1356
more information: https://dhs.iowa.gov/ime/providers/claims-and-billing/PA

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.

MEDICAID SUPPLEMENTAL INFORMATION
PRIOR AUTHORIZATION FORM

Sheet ___ of ___

MEMBER INFORMATION

Medicaid/Member ID

Last Name, First

Date of Birth (MMDDYYYY)

Requesting Provider Address

(Street Address) (City) (State) (Zip Code)

Servicing Provider Address

(Street Address) (City) (State) (Zip Code)

ADDITIONAL DIAGNOSIS CODES

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

ADDITIONAL PROCEDURE CODES

Procedure Code (CPT/HCPCS)	(Modifier)	Total Units/Visits/Days	Procedure Code (CPT/HCPCS)	(Modifier)	Total Units/Visits/Days

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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.