

**Precertification request for: durable medical equipment, skilled home care, home infusion, pain management, hyperbaric, hospice, dialysis and chiropractic care**

**Fax:** 1-877-244-1723; **Phone:** 1-800-454-3730

**This form should only be used for those services listed above.**

To prevent delay in processing your request, please fill out form in its entirety with all applicable information. All other precertification requests:

**General fax:** 1-800-964-3627; **DSNP fax:** 1-888-235-8468; **MLTSS fax:** 1-888-826-9762

Member information	
Full name:	
Amerigroup Community Care member ID:	
Address:	
City, state, ZIP code:	
DOB:	
Contact phone:	
Additional member information:	

Referring provider		<input type="checkbox"/> Participating	<input type="checkbox"/> Nonparticipating
Full name:			
NPI:	Provider ID:	TIN:	
Office contact name:			
Office phone:	Office fax:		
Address:			
City, state, ZIP code:			
Specialty:			

Servicing provider		<input type="checkbox"/> Participating		<input type="checkbox"/> Nonparticipating	
Full name:					
NPI:		Provider ID:		TIN:	
Office contact name:					
Office phone:		Office fax:			
Address:					
City, state, ZIP code:					
Specialty:		Continuity of care request: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Servicing facility		<input type="checkbox"/> Participating		<input type="checkbox"/> Nonparticipating	
Full name:					
NPI:		NPI:		NPI:	
Facility contact name:					
Facility phone:		Facility fax:			
Address:					
City, state, ZIP code:					

Requested service (For type of service, check all that apply.)			
Date/date range of service:	From:		To: 
ICD-10 code(s):			
CPT code(s) (or HCPCS code[s]) for outpatient services; include requested units:			
Type of service:	<input type="checkbox"/> Diagnostic study <input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Home health <input type="checkbox"/> Home infusion <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric <input type="checkbox"/> Office visit <input type="checkbox"/> Outpatient <input type="checkbox"/> Pain management <input type="checkbox"/> Other: _____		
Place of service:	<input type="checkbox"/> Ambulatory surgery center <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Independent lab <input type="checkbox"/> Office <input type="checkbox"/> Nursing facility <input type="checkbox"/> Other: _____		
Contact phone:			
Additional information:	<input type="checkbox"/> Routine <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Expedited		

**Disclaimer:** Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Amerigroup claims payment policy procedures.