

Washington Prior Authorization Form

Fax numbers:

- Home Health, home infusion, and durable medical equipment requests: **844-528-3681**
- Outpatient therapy, bariatric, pain management, podiatry, and orthotics/prosthetics requests: **855-231-8664**
- Skilled nursing, inpatient rehabilitation, long-term acute care hospital requests: **855-225-9940**
- Other precertification requests: **800-964-3627** (or call **800-454-3730** for information)

Emergent/urgent: Use for all non-elective **inpatient** admissions or **outpatient** services only when the service was urgent, emergent, or expedited. This is limited to instances where authorization decisions could seriously jeopardize the enrollee's life or health, or ability to attain, maintain, or regain maximum function.

To prevent a delay in processing, please complete this form in its entirety and submit all clinical information to support your request.

Today's date:	Provider return fax:	Provider return phone:
Member information		
First name:	Last name:	Member ID:
DOB:	Contact phone:	
Address:	City, state, ZIP:	
Additional member information:		
Referring provider	<input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating	
Full name:	Specialty:	
NPI:	TIN:	Provider ID:
Contact name:	Office phone:	Office fax:
Address:	City, state, ZIP:	
Servicing provider	<input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating	
Full name:	Specialty:	
NPI:	TIN:	Provider ID:
Contact name:	Office phone:	Office fax:
Address:	City, state, ZIP:	
Servicing facility	<input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating	
Name:		
NPI:	TIN:	Provider ID:
Contact name:	Facility phone:	Facility fax:
Address:	City, state, ZIP:	
Requested service		
Date/date range of service:	Number of units required:	
ICD-10 code(s):		
CPT® codes and units requested:		
For outpatient therapy, the number of <i>units</i> used on current authorization:		
For outpatient therapy, the date of the member's last session:		

Type of service
 Diagnostic study DME Home health Hospice Inpatient

(Check all that apply.):
 LTC/LTSS Observation extension Office visit Outpatient Personal care services Skilled nursing facility Other: _____

Place of service:
 Ambulatory surgery Home Hospital Independent lab Nursing facility Office Other: _____

Additional information: _____

If this is a request for extension or modification of an existing authorization, provide the authorization number:

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