Outpatient Authorization Supplemental Form

This page is optional and meant to be used when an authorization request exceeds more than 4 Procedure Codes. When applicable, please submit this form with Outpatient Prior Authorization Form to the applicable fax number.

SECTION I – PATIENT INFORMATION

Subscriber Name:	Phone:	DOB:	Male ◯ Female ◯
Member Name (If different from subscriber Name):	Member ID #:	Group Name or Number:	

SECTION II – PROVIDER INFORMATION

Name:	
NPI:	TIN:

SECTION IV – SERVICES REQUESTED (WITH CPT, CDT, OR CHPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version 10)	Code

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.

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.