arizona complete health
Complete Care Plan

OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and **Fax** to: 855-764-8513

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐

☐ **Standard requests -** Standard Request - Determination within 14 calendar days of receiving all necessary information

☐ **Urgent requests -** Expedited Request -I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Medicaid/Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name, First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUESTING PROVIDER INFORMATION

*Requesting NPI ☐☐☐☐☐☐☐☐☐☐

*Requesting TIN ☐☐☐☐☐☐☐☐☐

Requesting Provider Contact Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Requesting Provider Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone ☐☐☐☐☐☐☐☐☐☐

*Fax ☐☐☐☐☐☐☐☐☐☐

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ 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 Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

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

*Diagnosis Code ☐☐☐.☐☐☐ (ICD-10)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

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

Total Units/Visits/Days ☐☐☐☐

*OUTPATIENT SERVICE TYPE

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

412 Auditory
422 Biopharmacy
712 Cochlear Implants and Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
927 Hospice Outpatient
290 Hyperbaric Oxygen Therapy
112 Nutritional Supplements and/or services
249 Home Health
927 Hospice Outpatient
290 Hyperbaric Oxygen Therapy
410 Observation
790 Occupational Therapy
924 Office Visit/Chiropractic
997 Office Visit/Consult (nonpar)
375 Office Visit/Dental
370 Office Visit/Dermatology
365 Office Visit/Vaccines
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
101 Physical Therapy
650 Radiation Therapy
201 Sleep Study
701 Speech Therapy
472 Stereotactic Radiosurgery
992 Transplant
724 Transportation

DME
417 Rental
147 Prosthetics
120 Purchase $ ☐☐☐☐☐ (Purchase Price)

Behavioral Health
515 BH Electroconvulsive Therapy
519 BH Outpatient Therapy
520 BH Professional Fees
523 BH Transportation

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.

Rev. 09 24 2018
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