MEDICARE OUTPATIENT AUTHORIZATION

CALIFORNIA HEALTHNET

Standard/ Expedited Requests:844-501-5713
Transplant Requests: 833-769-1143

☐ Request for additional units. Existing Authorization _____ Units _____

For Standard requests, complete this form and FAX to 844-501-5713. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

For Expedited requests. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

*** INDICATES REQUIRED FIELD**

X _____

EXPEDITED REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

MEMBER INFORMATION

Last Name, First

Member ID*

Date of Birth *

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

Requesting NPI*

Requesting TIN*

Phone

Requesting Provider Address

Fax*

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

Servicing Provider Contact Name

Servicing NPI*

Servicing TIN*

Phone

Fax

Servicing Provider/Facility Name Address

City, State, Zip

AUTHORIZATION REQUEST

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

Additional Procedure Code (Modifier)
(CPT/HCPCS)

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)

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home health
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
141 Imaging
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
422 Biopharmacy
428 Second Opinion
997 Office Visit/Consult

DME (Orthotics and Prosthetics)

120 Purchase
417 Rental (Purchase Price)

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.

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XE-PAF-1652

Outpatient Authorization Supplemental Form

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

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

* Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
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Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days

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.

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