

## **MEDICARE OUTPATIENT AUTHORIZATION**

INDIANA

All Part B Drug Requests: **Fax** 844-943-1507 Expedited Requests: **Call** 855-766-1541 Standard Requests: **Fax** 844-208-4156 Transplant Requests: **Fax** 833-783-0875 Behavioral Health Requests: **Fax** 833-516-2668

For Standard requests, complete this form and FAX to the appropriate department. Determination multic as expeditionly as the certaine's length condition requests, but no later than Medical department and place the excellent site of the properties	Request for additional units. Existing Autho	rization		U	Inits	544
## INDICATES REQUIRED FIELD  MEMBER INFORMATION  Member ID*  Last Name, First  PROJUCTION PROVIDER INFORMATION  Requesting PROVIDER INFORMATION  Requesting PROVIDER INFORMATION  Requesting PROVIDER INFORMATION  Requesting Provider Name  Phone  Page Provider Contact Name  Phone  Pho			department. [	etermination made	as expeditiously as the e	nrollee's health
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Requesting NPI* Requesting Provider Name  Phone  Phone  Fax*  Servicing Provider Name  Phone  Fax  Servicing Provider Contact Name  Phone  Fax  Servicing Provider Contact Name  Fax  Servicing Provider Contact Name  Servicing Provider Contact Name	Member ID*		Last Name, First		(MMDDYYYY)	
Requesting NPI* Requesting Provider Name  Phone  Phone  Fax*  Servicing Provider Name  Phone  Fax  Servicing Provider Contact Name  Phone  Fax  Servicing Provider Contact Name  Fax  Servicing Provider Contact Name  Servicing Provider Contact Name						
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Plume   Fax	Requesting NPI*	Requesting TIN*		Requesting F	Provider Contact Name	
SERVICING PROVIDER / FACILITY INFORMATION  Same as Requesting Provider  Servicing RN*  Servicing RN*  Servicing Provider Contact Name  Phone  Fax   Additional Procedure Code  Bend Date OR Discharge Date  Total Units/Visits/Days  Description  Total Units/Visits/Days  Behavioral Health  Stol Bit Medical Management  Stol Bit Medical Management  Stol Bit Medical Management  Stol Bit Medical Medic		nequecting in				
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AUTHORIZATION REQUEST  Primary Procedure Code * Additional Procedure Code   Start Date OR Admission Date * Diagnosis Code *					······································	
Primary Procedure Code  Additional Procedure Code  End Date OR Discharge Date  Total Units/Visits/Days  (CPT/HCPCS) (Modifier) (MMDDYYYY)   OUTPATIENT SERVICE TYPE*  (Enter the Service type number in the boxes)  (Enter the Service type number in the boxes)  650 Radiation Therapy  920 Drug Testing  920 Study  920 Experimental & Investigational Services  933 Transplant Evaluation  925 Genetic Testing & Counseling  209 Transplant Surgery  417 Transportation  729 Neuropsychological Testing  930 Hoperbaric Oxygen Therapy  335 Infertility Diagnosis or Treatment  730 Occupational Therapy  345 Infertility Diagnosis or Treatment  730 Occupational Therapy  734 Outpatient Services  735 DME (Orthotics and Prosthetics)  510 BH Community Based Services  511 BH Community Based Services  512 BH Community Based Services  513 BH Outpatient Therapy  514 BH Day Treatment  515 BH Electroconvulsive Therapy  518 BH Mental Health/Chemical Dependency Observation  519 BH Outpatient Therapy  510 DME (Orthotics and Prosthetics)  511 BH Psychological Testing  512 BH Psychological Testing  513 BH Professional Fees  514 BH Psychological Testing  515 BH Escriptional Dependency Observation  516 BH Psychological Testing  517 Outpatient Surgery  518 BH Psychological Testing  519 BH Psychological Testing  510 BH Psychological Testing  511 BH Psychological Testing  512 BH Psychological Testing  513 BH Psychological Testing  514 BH Psychological Testing  515 BH Psychological Testing  516 BH Psychological Testing  517 Outpatient Surgery  518 BH Psychological Testing  519 BH Psychological Testing  510 BH Psychological Testing  511 BH Psychological Testing  512 BH Psychological Testing  513 BH Psychological Testing  514 BH Psychological Testing  515 BH Escription  516 BH Psychological Testing  517 BH Psychological Testing  518 BH Psychological Testing  519 BH Psychological Testing  510 BH Psychological Testing	Servicing Provider/Facility Name	Pr	ione	şşş	Fax	
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COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.