western sky community care

OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and **Fax** to: 844-805-4593

☐ 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) ☐☐☐

422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
660 Hearing Needs
249 Home Health
225 Home Meals
390 Hospice Services
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
201 Sleep Study
472 Sterotactic Radiosurgery
724 Transport

DME

417 Rental
120 Purchase Purchase Price $

THERAPY

790 Occupational
279 Occupational Evaluation
101 Physical
971 Physical Evaluation
701 Speech
127 Speech Evaluation

BEHAVIORAL HEALTH

512 BH community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH Partial Hospital Program
522 BH Psychiatric Evaluation
521 BH Psychological Testing

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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