OUTPATIENT
Prior Authorization Fax Form

Fax to:
855-537-3447

ambetter. FROM superior healthplan

☐ Request for additional units. Existing Authorization _____ Units _____

☐ Standard and Urgent Pre-Service Requests - Determination within 3 calendar days (72 hours) of receiving the request

***** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID *

Last Name, First

Date of Birth (MMDDYYYY)

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 * 1952588329

Servicing TIN * 208424689

Servicing Provider Contact Name Monica C.

Servicing Provider/Facility Name City Ambulance Service

Phone 2815717080 ext 525

Fax 3466426422

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 Services
422 Biopharmacy
924 Chiropractic
712 Cochlear Implants and Surgery

Dental Anesthesia
911 Office Visit
721 Other Site

771 Dialysis

DME
417 Rental
120 Purchase $ (Purchase Price)

299 Drug Testing
709 Genetic Testing
249 Home Health
290 Hyperbaric Oxygen Therapy
611 Infertility Treatments
211 OB Ultrasound(s)

497 Office Visit/Specialty Consult
210 Orthotics
927 Outpatient Hospice
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
201 Sleep Study
724 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.