

Outpatient Authorization Form Continued

This page is optional and meant to be used when a request exceeds more than four (4) Procedure Codes.

* INDICATES REQUIRED FIELD				
MEMBER INFORMATION		*	*Date of Birth (MMDDYYYY)	
* Medicaid/Member ID	L	ast Name, First		
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	
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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. Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution,

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