



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

* 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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End Date

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End Date

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End Date

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Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days