



OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Buy & Bill Drug Requests: **Fax** 833-341-2049
Standard/Urgent Requests: **Fax** 833-467-1237
Behavioral Health Requests: **Fax** 833-655-2191
Transplant Requests: **Fax** 833-920-4419

☐ Request for additional units. Existing Authorization Units

☐ **Standard Requests** - Determination within 7 calendar days of receipt of request.

☐ **Urgent Requests** - 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

*Medicaid/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

*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)

412 Auditory
712 Cochlear Implants & Surgery
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
141 Imaging (NIA, if not managed by Meridian)
395 Infertility Diagnosis or Treatment
997 Office Visit/Consult

794 Outpatient Services (including Speech Therapy)
171 Outpatient Surgery
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Drugs

422 Biopharmacy Buy & Bill Drugs
(Fax Buy & Bill Drug Requests to 833-341-2049)

Behavioral Health

521 BH Psychological Testing

DME

417 Rental

120 Purchase

(Purchase Price)

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.

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.

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