OUTPATIENT MEDICARE AUTHORIZATION FORM

allwell. FROM silversummit healthplan.

All Part B Drug Requests: **Fax** 844-960-1789
Expedited Requests: **Call** 833-854-4766
Standard Requests: **Fax** 833-238-7694
Transplant Requests: **Fax** 833-414-1491

☐ Request for additional units. Existing Authorization _____ Units _____

For All Standard or Expedited Part B Drug requests, please fax to 844-960-1789

For Standard (Elective Admission) requests, complete this form and FAX to the appropriate department. Determination made as expeditiously as the enrollee's health condition requires, but no later than **14** calendar days after receipt of request.

For Expedited requests, please CALL 833-854-4766. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

*** 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*

Servicing TIN*

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

If this request is for a Part B DRUG, please fax to 844-952-1487.

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) ☐☐☐

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home health
290 Hyperbaric Oxygen Therapy
141 Imaging
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
422 Biopharmacy (Please fax to 844-952-1487)

DME

417 Rental
120 Purchase _____ (Purchase Price)

Behavorial Health

510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

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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