louisiana healthcare connections

OUTPATIENT
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-877-401-8175

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

Is this for Discharge Needs? Yes ☐ No ☐ Chronic Needs Case: Yes ☐ No ☐

☐ Standard Request - Determination within 14 calendar days of receipt of the request.

☐ Urgent Request - 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.

X _____

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PRACTITIONER TO RECEIVE PRIORITY.

***** *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

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 ☐☐☐☐

ESPD Coordinator Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ESPD Coordinator Phone ☐☐☐☐☐☐☐☐☐☐

ESPD Coordinator Fax ☐☐☐☐☐☐☐☐☐☐

OUTPATIENT SERVICE TYPE * *(Enter the Service type number in the boxes)*

412 Auditory Services
422 Biopharmacy
924 Chiropractic
712 Cochlear Implants & Surgery

Dental Anesthesia
911 Office Visit
721 Other Site

771 Dialysis

DME
417 Rental
120 Purchase

299 Drug Testing
709 Genetic Testing
249 Home Health
290 Hyperbaric Oxygen Therapy
729 Neuropsych Testing

Nutritional Supplements and/or Services
407 Enteral Feedings
102 Medical Food and Thickener
441 Parenteral Feedings

410 Observation
497 Office Visit/Specialty Consult
210 Orthotics
927 Outpatient Hospice

☐☐☐ *Observation requires Authorization after 31 hours or more*

794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
470 Personal Care Worker Services
147 Prosthetics
650 Radiation Therapy
201 Sleep Study
724 Transportation

Outpatient Surgery Examples:
- *Bone Marrow Biopsy/Aspiration*
- *Hysterectomy*
- *Mammoplasty*
- *Rhino/Septoplasty*

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.