



# 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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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

**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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