

# Outpatient Authorization Supplemental Form

This page is optional and meant to be used when an authorization request exceeds more than four (4) Procedure Codes. When applicable, please submit this form with the Outpatient Prior Authorization Form to the applicable fax number.

\* INDICATES REQUIRED FIELD

## MEMBER INFORMATION

<p>* Medicaid/Member ID</p> <div style="border: 1px dashed black; width: 370px; height: 25px; margin-bottom: 5px;"></div> <div style="border: 1px dashed black; width: 370px; height: 25px;"></div>	<p>Last Name, First</p> <div style="border: 1px dashed black; width: 200px; height: 25px; margin-bottom: 5px;"></div> <div style="border: 1px dashed black; width: 200px; height: 25px;"></div>	<p>*Date of Birth (MMDDYYYY)</p> <div style="border: 1px dashed black; width: 100px; height: 25px; margin-bottom: 5px;"></div> <div style="border: 1px dashed black; width: 100px; height: 25px;"></div>
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## AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
<div style="border: 1px dashed black; width: 80px; height: 20px;"></div>	<div style="border: 1px dashed black; width: 140px; height: 20px;"></div>	<div style="border: 1px dashed black; width: 140px; height: 20px;"></div>	<div style="border: 1px dashed black; width: 80px; height: 20px;"></div>
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
<div style="border: 1px dashed black; width: 80px; height: 20px;"></div>	<div style="border: 1px dashed black; width: 140px; height: 20px;"></div>	<div style="border: 1px dashed black; width: 140px; height: 20px;"></div>	<div style="border: 1px dashed black; width: 80px; height: 20px;"></div>
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