130 DeSiard Street, Ste. 300 Monroe, LA 71201
Phone: 318-361-0900
Fax: 318-361-2170

OUTPATIENT PRIOR AUTHORIZATION FORM

Request Date: _____ Provider's Name: _____

To: Medical Management Department

Fax Number: 318-361-2170 Fax #: _____

Patient Name: _____ Phone Number: _____

Insured ID: _____ Contact: _____

☐ Medicare ☐ Commercial ☐ Marketplace

Patient DOB: _____ Age: _____ PCP: _____

Date of Service: _____ Prior Authorization #: _____

Ordering MD: _____ ☐ Outpatient ☐ Inpatient

Provider's NPI: _____

Place of Service: _____ Facility NPI: _____

Diagnosis: _____ ICD-10 Code: _____

_____ _____

Procedure to be performed: _____

CPT codes to be billed: _____,_____,_____,_____,_____

HCPC codes to be billed: _____,_____,_____,_____,_____

Attachments are to be included at all times, when available:

- ☐ Diagnostic procedures: Clinical Notes or Diagnostic Reports for procedure/surgery
- ☐ Admission: Clinical for planned admissions
- ☐ DME: Physician's Order, CMN, Sleep Study, Compliance Report, Clinical Notes
- ☐ DME: Date of Service when equipment was issued to patient: _____
- ☐ Therapy: Physician's Order, Evaluation, or Clinical notes

FOR EXPEDITED REVIEW [72 HOURS] REQUEST ONLY:

BY SIGNING BELOW, I AM REQUESTING AN EXPEDITED REVIEW AND CERTIFYING THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

SIGNATURE OF PHYSICIAN: _____