PRIOR AUTHORIZATION

Outpatient Medical / Surgical

Note: <u>Prior Authorization DOES NOT guarantee payment or client eligibility</u>

This request is ☐ **Initial** ☐ **Update to Prior Authorization #:**

Please indicate where you would like the determination letter sent to:

Provider Name:	**Fax #:**

Please check the box for the appropriate treatment type:

☐ **Surgery** ☐ **Diagnostic Radiology** ☐ **Therapeutic Radiology** ☐ **Vision (Optometry)**

PATIENT INFORMATION		
Name:		Medicaid ID #:
Street Address:		
City, State, Zip Code:		
DOB:	Age:	Telephone:
SECTION 1: SUBMITTING PROVIDER INFORMATION		
Treating Provider Name:		
Provider NPI#:		Taxonomy:
Street Address:		
City, State, Zip Code:		
Telephone:		Contact Name:
SECTION 2: SERVICING PROVIDER (PAY TO PROVIDER) INFORMATION		
Pay-To Provider Name or Provider Group Name:		
Pay-To Provider NPI or Provider Group NPI:		
Taxonomy:		
Street Address:		
City, State, Zip Code:		
Telephone:		Contact Name:

SERVICE INFORMATION				
Proposed Dates of Service:			From:	To:
Service Description:	Diagnosis Code	Procedure Code	Modifier(s)	Units

****REQUIRED ATTACHMENTS****

SUPPORTING DOCUMENTATION SHOWING MEDICAL NECESSITY: Please ensure all required documentation is attached to your request at the time of the request. Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the service. Additional documentation may be attached when necessary.

Forms can be found on-line at wymedicaid.telligen.com