Iowa Medicaid
Iowa HHS

OUTPATIENT MEDICAID
PRIOR AUTHORIZATION FORM

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

Mark Standard or Urgent Request if initial request

☐ **Standard requests -** Determination within 7 calendar days from receipt of all necessary information.

☐ **Urgent requests -** Expedited request necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function. Authorization decision will be done within **72** hours of receipt of request. **42 CFR §438.210**

☐ **Iowa Total Care** ☐ **Wellpoint** ☐ **Molina Healthcare** ☐ **Fee for Service**

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Date of Birth* (MMDDYYYY)

Medicaid ID*

Last Name, First

REQUESTING PROVIDER INFORMATION *Address Required on Supplemental*

Form Requesting NPI*

Requesting TIN*

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax*

SERVICING PROVIDER / FACILITY INFORMATION *Address Required on Supplemental Form*

↳ ☐ Same as Requesting Provider

Servicing NPI*

Servicing TIN*

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

*Servicing Provider Address

*City

*State

*Zip

AUTHORIZATION REQUEST

*Primary Diagnosis Code

(ICD-10)

***Primary** Procedure Code (CPT/HCPCS) (Modifier)

***Start Date OR** Admission Date (MMDDYYYY)

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

*Place Of Service Code

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date OR Admission Date (MMDDYYYY)

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

Place Of Service Code

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date OR Admission Date (MMDDYYYY)

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

Place Of Service Code

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date OR Admission Date (MMDDYYYY)

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

Place Of Service Code

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.

Iowa Medicaid
Iowa HHS

MEDICAID SUPPLEMENTAL INFORMATION
PRIOR AUTHORIZATION FORM

Sheet ___ of ___

MEMBER INFORMATION

Medicaid/Member ID

Last Name, First

Date of Birth

(MMDDYYYY)

Requesting Provider Address

(Street Address) (City) (State) (Zip Code)

Servicing Provider Address

(Street Address) (City) (State) (Zip Code)

ADDITIONAL DIAGNOSIS

Diagnosis Code (ICD-10)

Diagnosis (ICD-10)

Diagnosis (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis (ICD-10)

Diagnosis (ICD-10)

ADDITIONAL PROCEDURE CODES

Procedure Code (CPT/HCPCS) (Modifier)

Total Units/Visits/

Procedure Code (CPT/HCPCS) (Modifier)

Total Units/Visits/

Procedure Code (CPT/HCPCS) (Modifier)

Total Units/Visits/

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Total Units/Visits/

Procedure Code (CPT/HCPCS) (Modifier)

Total Units/Visits/

Procedure Code (CPT/HCPCS) (Modifier)

Total Units/Visits/

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.

Iowa Medicaid
Iowa HHS

Outpatient Medicaid Prior Authorization Resources

WELLPOINT

Physical Health UM Fax #	800-964-3627
Behavioral Health Fax #	844-451-2826
Precertification Lookup Tool (PLUTO)	provider.wellpoint.com/iowa-provider/resources/prior-authorization-requirements/prior-authorization-lookup
Availity Login	apps.availity.com/availity/web/public.elegant.login
Contact Wellpoint (Providers)	provider.wellpoint.com/iowa-provider/home

IOWA TOTAL CARE

Physical Health Fax #	833-257-8327
Buy & Bill Drug Requests Fax #	833-711-0485
Behavioral Health Fax #	844-908-1169
Place of Service Code Sets Full List	cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

MOLINA HEALTHCARE

Availity Login	apps.availity.com/availity/web/public.elegant.login
UM Fax #	1-877-319-6828
Provider Toll Free Number	1-844-236-1464
Advanced Imaging Fax #	877-731-7218
Transplant Fax #	877-813-1206

MEDICAID FEE FOR SERVICE

Fee for Service	hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments/prior-authorization
Fax #	515-725-1356