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 14 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	***Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	*Place Of Service Code
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

Additional Procedure Code	**Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	Place Of Service Code
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

Additional Procedure Code	**Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	Place Of Service Code
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

Additional Procedure Code	**Start Date OR** Admission Date	**End Date OR** Discharge Date	Total Units/Visits/Days	Place Of Service Code
(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(MMDDYYYY)		

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.