



# MEDICARE OUTPATIENT AUTHORIZATION NEBRASKA

All Part B Drug Requests: **Fax** 833-981-4181  
Expedited Requests: **Call** 833-853-0864  
Standard Requests: **Fax** 833-981-4176  
Transplant Requests: **Fax** 833-981-4184  
Behavioral Health Requests: **Fax** 833-981-4183

☐ Request for additional units. Existing Authorization  Units

**For Standard requests, complete this form and FAX to the appropriate department.** Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

**For Expedited requests, please CALL 833-853-0864.** Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

\* INDICATES REQUIRED FIELD

## MEMBER INFORMATION

Member ID \*  Last Name, First  Date of Birth \*  (MMDDYYYY)

## REQUESTING PROVIDER INFORMATION

Requesting NPI \*  Requesting TIN \*  Requesting Provider Contact Name   
Requesting Provider Name  Phone  Fax \*

## SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider  
Servicing NPI \*  Servicing TIN \*  Servicing Provider Contact Name   
Servicing Provider/Facility Name  Phone  Fax

## AUTHORIZATION REQUEST

Primary Procedure Code * <input type="text"/> (CPT/HCPCS) <input type="text"/> (Modifier)	Additional Procedure Code <input type="text"/> (CPT/HCPCS) <input type="text"/> (Modifier)	Start Date OR Admission Date * <input type="text"/> (MMDDYYYY)	Diagnosis Code * <input type="text"/> (ICD-10)
Additional Procedure Code <input type="text"/> (CPT/HCPCS) <input type="text"/> (Modifier)	Additional Procedure Code <input type="text"/> (CPT/HCPCS) <input type="text"/> (Modifier)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>

### OUTPATIENT SERVICE TYPE \*

(Enter the Service type number in the boxes)

712 Cochlear Implants & Surgery  
299 Drug Testing  
922 Experimental & Investigational Services  
205 Genetic Testing & Counseling  
249 Home Health  
290 Hyperbaric Oxygen Therapy  
395 Infertility Diagnosis or Treatment  
729 Neuropsychological Testing  
410 Observation  
997 Office Visit/Consult  
794 Outpatient Services  
171 Outpatient Surgery  
202 Pain Management  
422 Biopharmacy (Please fax to 833-981-4181)

650 Radiation Therapy  
201 Sleep Study  
993 Transplant Evaluation  
209 Transplant Surgery  
724 Transportation  
212 Therapy Evaluation  
790 Occupational Therapy  
101 Physical Therapy  
701 Speech Therapy

### DME (Orthotics and Prosthetics)

417 Rental   
120 Purchase  (Purchase Price)

### Behavioral Health

510 BH Medical Management  
530 BH Partial Hospitalization Program (PHP)  
512 BH Community Based Services  
513 BH Crisis Psychotherapy  
514 BH Day Treatment  
515 BH Electroconvulsive Therapy  
518 BH Mental Health/Chemical Dependency Observation  
519 BH Outpatient Therapy  
520 BH Professional Fees  
512 BH Psychological Testing  
522 BH Psychiatric Evaluation

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.

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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