Outpatient Authorization Form Continued

This page is optional and meant to be used when a request exceeds more than four (4) Procedure Codes.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

* Medicaid/Member ID   Last Name, First

AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
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