



Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

Amerigroup (MMP) Medicare Plan (Amerigroup Real Solutions Star+Plus Form)

Checklist:

- Obtain the patient's diagnosis, insurance name, and identification number
- Call MedStar non-emergency line at 817-927-9620
- Complete the form on the next page
- Pull clinical-supporting documentation to send with the Pre-Authorization paperwork
- Fax Pre-Authorization Paperwork to 888-235-8468
- Fax the completed Request Form and Fax Confirmation to 817-632-0537

***Please note: If transport is from ER to ER, an authorization is *NOT* required**

Precertification request

Phone: 1-855-878-1785

Fax: 1-888-235-8468

Today's date _____		Provider return fax # _____	
Member information (please verify eligibility prior to rendering service)			
Name (last name, first name):		Amerigroup #:	
Date of birth:			
Address:		City, State ZIP code:	
Medicaid #:	Medicare #:	Other insurance/Workers'	
Comp:			
Referring provider information			
Name:		Office contact name	
Medicaid provider #	Amerigroup #:	Group practice #:	
NPI #:			
Phone #:	Fax #:	Other phone #:	
Specialist consult			
Consultant: <i>(last name, first name, provider specialty)</i>			
Amerigroup provider#:	NPI #:	Phone #:	Fax #:
Address:		City, State ZIP code:	
ICD-10 code/diagnosis/reason for referral:			
PMH/previous studies/treatment:			
Number of visits required:			
Maternity care			
For initial notification of pregnancy, please use the maternity notification form. For all other services related to pregnancy, please use this form (e.g., ultrasound, fetal non-stress test).			
Diagnostic study			
Facility name:		Date of service:	
Diagnosis/reason for referral:			
Procedure/CPT-4 code:			
PMH/previous studies/treatments:			
Surgery request			
Surgeon's full name: <i>(last name, first name)</i>		Date of service: ___ <input type="checkbox"/> Inpt ___ <input type="checkbox"/> Outpt ___ <input type="checkbox"/> Ext stay	
Facility name:			
Diagnosis/reason for surgery:			
Procedure/CPT-4 code:			
PMH/previous studies/treatments:			
Other - clinical information needed			
<input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Home health <input type="checkbox"/> Hospice <input type="checkbox"/> Other			
Referred to provider: <i>(last name, first name)</i>		Amerigroup provider#:	
NPI #: 1710981774; Tax ID 75-2234266			
Diagnosis/reason for referral: ICD 10			
Procedure/CPT-4 code: <u>CPT A0428 (base rate) x _____, A0425</u>			
PMH/previous studies/treatments:			
Place of service: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Other Ambulance			
Please attach clinical information to support medical necessity: this referral is valid only for services authorized by this form. Only completed referrals will be processed. If the consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.			
To be completed by Amerigroup:		Date approved:	
Date span:	Reference #:	Initials of approver:	