

Prior Authorization Request Form

Amerigroup prior authorization: **800-454-3730** (phone); **800-964-3627** (fax).

To prevent delay in processing your request, please fill out form in its entirety with all applicable information.

Today's date:		Provider return fax:	
Member information			
First name:		Last name:	
Amerigroup member ID:		Contact phone:	
Address:		City, State ZIP code:	
Addition member information:			
Referring provider		Participating: <input type="checkbox"/>	Nonparticipating: <input type="checkbox"/>
Full name:		NPI:	
Specialty:		Provider ID:	
Tax ID number (TIN):		Office contact name:	
Office phone:		Office fax:	
Address:		City, State ZIP code:	
Servicing provider		Participating: <input type="checkbox"/>	Nonparticipating: <input type="checkbox"/>
Full name:	MedStar Mobile Healthcare	NPI:	1710981774
Specialty:	Ground Ambulance	Provider ID:	
Tax ID number (TIN):	75-2234266	Office contact name:	
Office phone:	817-923-3700	Office fax:	817-632-0537
Address:	2900 Alta Mere Dr	City, State ZIP code:	Fort Worth, Tx 76116
Servicing facility		Participating: <input type="checkbox"/>	Nonparticipating: <input type="checkbox"/>
Name:			
NPI:		Provider ID:	
Tax ID number (TIN):		Facility contact name:	
Facility phone:		Facility fax:	
Address:		City, State ZIP code:	
Requested service (for type of service, check all that apply)		Date/date range of service:	
ICD-10 code(s):			
CPT® code(s) (include requested units/visits):		A0428 x A0425 x A0382 x 1	
Modifier(s):			
Type of service:	<input type="checkbox"/> Outpatient <input type="checkbox"/> Planned inpatient <input type="checkbox"/> Emergent inpatient <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Long-term services & supports/long-term care <input type="checkbox"/> Home health <input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Diagnostic study <input type="checkbox"/> Hospice <input type="checkbox"/> Office visit <input type="checkbox"/> Personal care services <input checked="" type="checkbox"/> Other: <u>Ground ambulance</u>		
Place of service:	<input type="checkbox"/> Hospital <input type="checkbox"/> Ambulatory surgery center <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Independent lab <input type="checkbox"/> Nursing facility <input checked="" type="checkbox"/> Other: <u>Ambulance - Land 41</u>		
Additional information:			

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Amerigroup, please provide the authorization number with your submission in the Additional Information section.

Emergent – use for **all** nonelective **inpatient** admissions only, when provider indicates that the admission was urgent, emergent or expedited (for admission on same day).

Urgent – use for **outpatient** services only, when provider indicates that the service is urgent, emergent or expedited.