IMPORTANT INSTRUCTIONS FOR COMPLETING THIS FORM

Please read these instructions carefully before completing this form. Thank you!

- For each authorization request, please print a **new form** directly from our website. **Do not make copies of the form for future use**.
- Type your responses whenever possible. Handwriting is difficult for our automated ocular recognition software system to read; however, if you need to handwrite, please print and use black ink.
- Upload the prior authorization request with corresponding clinical documentation to our SDS portal at Provider.ExcellusBCBS.com/authorizations/sds-portal.
- Documents uploaded after 5 p.m. will not be processed until the following business day.
- To improve processing time, upload prior authorization requests and medical records one member at a time.
- Mark prior authorization requests as Urgent or Standard in the appropriate form field. If you handwrite "urgent" on the form or in the notes on a coverage page, it may be missed.
- If you do not receive a determination within the requested time frame, please call us before resending documents. If you do not call, a duplicate request could be processed, which delays intake.

Excellus

OUTPATIENT AUTHORIZATION FORM

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐

☐ **Standard requests -**

☐ **Urgent request -** I certify this request is urgent and medically necessary to treat an injury, illness, or condition (not life threatening) to avoid complications and unnecessary suffering or severe pain.

*** INDICATES REQUIRED FIELD**

After hours, weekends, and holidays requests will be processed the next business day as received.

MEMBER INFORMATION

*Date of Birth ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Medicaid/Member ID

Last Name, First

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 ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

***Start Date** OR Admission Date ☐☐☐☐☐☐☐☐ (MMDDYYYY)

*Diagnosis Code ☐☐☐☐☐☐☐ (ICD-10)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

Additional Procedure Code ☐☐☐☐☐ (CPT/HCPCS) ☐☐ (Modifier)

End Date OR Discharge Date ☐☐☐☐☐☐☐☐ (MMDDYYYY)

Total Units/Visits/Days ☐☐☐☐

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) ☐☐☐

760 Air Ambulance (Non-Emergent)
712 Cochlear Implants & Surgery
911 Dental Anesthesia - Office Visit
709 Genetic Testing
249 Home Health
305 Long Term Services & Support

790 Occupational Therapy
497 Office Visit/Specialty Consult
927 Outpatient Hospice
794 Outpatient Services
210 Orthotics
☐☐☐☐☐☐ (Purchase Price)

912 Oxygen Equipment/Gas Supply

202 Pain Management
101 Physical Therapy
147 Prosthetics
☐☐☐☐☐☐ (Purchase Price)

701 Speech Therapy
411 Surgical Procedures
310 Vision

DME
417 Rental
120 Purchase ☐☐☐☐☐☐ (Purchase Price)

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.

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