Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH

OUTPATIENT MEDICAID AUTHORIZATION FORM

Complete and Fax to:
Expressive Therapies/Residental/Treatment Foster Care/Medical: 1-833-966-0769
Behavorial/PRTF: 1-833-966-4342

☐ Request for additional units. Existing Authorization _____ Units _____

☐ **Standard requests -** Determination within 14 calender days of receiving all necessary information.

☐ **Urgent requests** - I certify this request is urgent to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 72 hours.

X _____ Urgent requests must be signed by the requesting physician to receive priority

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Medicaid/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 (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) _____

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
141 Imaging
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management

101 Physical Therapy
701 Speech Therapy
790 Occupational Therapy
209 Transplant Surgery
992 Transplant Evaluation
724 Transportation

DME
417 Rental
120 Purchase _____ (Purchase Price)

Behavioral Health
510 Medical Management
530 Partial Hospital Program
513 Crisis Psychotherapy
514 Day Treatment
515 Electroconvulsive Therapy
516 Intensive Outpatient Therapy
518 Mental Health/Chemical Dependency Observation
519 Outpatient Therapy
520 Professional Fees
521 Psychological Testing
522 Psychiatric Evaluation
536 BH Residential Treatment-Mental Health

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 OR DENIAL.

Rev. 09 17 2025
MO-PAF-0711