

Precertification request ▪ Phone: 1-800-454-3730 ▪ Fax: 1-800-964-3627

Today's date:

Return fax for prior authorization:

Please attach clinical information to support medical necessity

Disclaimer: Authorization is based on verification of member eligibility and benefit coverage at the time of service and is subject to Amerigroup Kansas, Inc. claims payment policies and procedures

Member information

Name (Last, first): _____ Amerigroup ID #: _____ Date of birth: _____
 Address: _____ City, State ZIP code: _____
 State Medicaid ID #: _____ Other insurance/worker's comp: _____

Service/prior authorization request - if requesting durable medical equipment (DME), please include modifier(s), cost and pricing information.

Service type (check all that apply): DME Occupational therapy Physical therapy Speech therapy Home health Hospice
 Pharmacy Dental surgery Other (please describe) _____

Place of service: Office Home Off-campus outpatient On-campus outpatient Other _____

Requested dates of service: _____

ICD-10 diagnosis code(s): _____

CPT codes: _____

Of units/visits and frequency requested: _____

Servicing provider

Provider name: (Last, First, Provider specialty) _____

Amerigroup provider/group ID #: _____ Office contact name: _____

Network status: Par Out-of-network (OON) _____ Phone #: _____

If OON, will you accept KS Medicaid rates? yes no _____ Fax #: _____

Tax ID #: _____ Address: _____

NPI #: _____ City, State ZIP code: _____

Have you seen this member before? Yes No _____

Ordering/referring provider

Provider name: (Last, First) _____ Office contact name: _____

Amerigroup provider/group ID #: _____ Phone #: _____

Tax ID #: _____ Fax #: _____

NPI #: _____ Address: _____

Network status: Par OON _____

Facility

Facility name: _____

Amerigroup provider/facility ID #: _____ Office contact name: _____

Network status: Par OON _____ Phone #: _____

If OON, will you accept KS Medicaid rates? yes no _____ Fax #: _____

Tax ID #: _____ Address: _____

NPI #: _____ City, State ZIP code: _____

Provider name: (Last, First, Provider specialty) _____

Maternity care

For initial notification of pregnancy, please use the Maternity Notification Form found under Maternal Child Program at providers.amerigroup.com.

For all other services related to pregnancy, please use this form (e.g., a second ultrasound, fetal non-stress test).

Surgery request

Surgeon's full name: (Last, First) _____

Facility (please fill out facility and service information above) _____

Inpatient Off-campus outpatient On-campus outpatient Extended stay _____

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 confirm precertification is required for this service, use the Precertification Lookup tool on the provider self-service website at providers.amerigroup.com. All rentals and out-of-network services require prior authorization when Amerigroup is primary.