Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Out-of-Network Precertification Request Form

Prior authorization phone: 1-800-454-3730 Fax: 1-877-423-9965

To prevent any delay in processing your request, please fill out this form in its entirety.

Today's date: **Provider return fax:**

Standard request ☐ **Expedited request** ☐

If expedited, urgent or emergent, please explain:

Justification for out-of-network (OON) request

Has the member seen an OON provider before? ☐Yes ☐No If yes, date last seen:

Date referred: Diagnosis treated (may use code):

Member information

First name: Last name: Member ID:

DOB: Phone:

Referring provider ☐ **Participating** ☐ **Nonparticipating**

Full name:

NPI: TIN:

Office contact name: Phone: Fax:

Location: Specialty:

Servicing provider ☐ **Participating** ☐ **Nonparticipating**

Full name:

NPI:

Office contact name: Phone: Fax:

Location: Specialty:

Servicing facility ☐ **Participating** ☐ **Nonparticipating**

Full name:

NPI:

Office contact name: Phone: Fax:

Location:

Requested service

Type of service: *Check all that apply.*

☐ Outpatient ☐ Home health ☐ Hospice ☐ Office visit
☐ Emergent inpatient ☐ Planned inpatient ☐ Diagnostic study ☐ Skilled nursing facility
☐ Personal care services ☐ Long-term services and supports/long-term care ☐ Durable medical equipment ☐ Other:

Place of service:

☐ Hospital ☐ Nursing facility ☐ Office ☐ Home
☐ Independent ancillary (i.e., lab, radiology) ☐ Ambulatory surgery center ☐ Other:

Dates of service: **Clinical documentation attached? ☐ Yes ☐ No**

ICD-10 code(s):	CPT/HCPCS code(s):	Units:

Please submit all appropriate clinical information, provider contact information and any other necessary documents with this form to support your request. If this is a request for extension or modification of an existing authorization, provide the authorization.

Existing authorization reference ID: