MEDICAID Prior Authorization Request Form – OUTPATIENT

Please fax to: 1-877-809-0790 (Home Health Services) or 1-877-809-0787 (All Other Requests)
(Phone: 1-877-725-2688

Cigna HealthSpring CarePlan
TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

*** Required Field – please complete all required fields to avoid delay in processing**

Note: In an effort to process your request in a timely manner, please submit any pertinent clinical information (i.e. progress notes, treatment rendered, test/lab results or radiology reports) to support the request for services. Any request for a non-contracted provider must include documentation to substantiate the reason for the request. **(When all required information has been submitted we will complete your request within 3 business days.)**

☐ Expedited Requests – defined as ***danger to a member's health if not provided within 24 hours.***
(Phone: 1-877-725-2688 Then press prompt 3, for expedited prior authorization.

Member Information:

***Member Name:**		
***Member DOB: / /**	*** Member ID:**	***Date of Service: / /**

Requesting Provider Information:

***PCP/Requesting Provider:**	Contact Person: ***Phone #:** ***Fax #:**

Referring to (servicing) provider information: if below fields are not answered, Cigna-HealthSpring® will automatically assign Cigna-HealthSpring's participating provider network to the member:

***Servicing Provider:** ☐ Non-contracted Tax ID #: NPI#:	Contact Person: ***Phone #:** ***Fax #:**
***Facility:** ☐ Non-contracted Tax ID #: NPI#:	Contact Person: ***Phone #:** ***Fax #:**

If requesting a non-contracted provider/facility, please explain why:

***Type of Service:**
Please check only one of the boxes:

☐ ASC	☐ Elective Outpatient Surgery	☐ Prosthetics/Orthotics
☐ MRI/MRA/CT PET	☐ Office Procedure	☐ Home Health
☐ PT/OT/ST	☐ Transplant Evaluation	☐ Ambulance
☐ Cosmetic/Reconstructive	☐ DME	☐ Other _____
	☐ Medication	

Clinical Information:

***Diagnosis Code:**	Diagnosis:	
***Procedure/Service Requested:**	☐ CPT Code:	☐ HCPCS Code:
Procedure/Service Description:		
Number of visits:	Duration:	
Frequency of visits:	Number of previous visits:	
***Is supporting Clinical Information Attached?**	Yes	No - Please summarize clinical information below

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