

Apr/25/2025 12:22:55 PM

HCA 8439705814

1/17

Received by Centene: 2025-04-25 11:03:33 CST

Complete and Fax to: 1-844-560-0799

Transplant Fax to: 1-833-414-1667



OUTPATIENT AUTHORIZATION FORM

Request for additional units.

Existing Authorization

Units

☒ **Standard requests** - Determination within 15 calendar days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE
PHYSICIAN TO RECEIVE PRIORITY

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Member ID

U9541367801

Last Name, First

DE LOS SANTOS MARIN,
DANIEL

*Date of Birth

08011947

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI

1366496937

*Requesting TIN

621768106

Requesting Provider Contact Name

Amanda K

Requesting Provider Name

Trident Medical
Center

Phone

8439705021

*Fax

8438325118

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

93798

(CPT/HCPCS)

(Modifier)

Additional Procedure Code

(CPT/HCPCS)

(Modifier)

*Start Date OR Admission Date

05142025

(MMDDYYYY)

*Diagnosis Code

I214

(ICD-10)

Additional Procedure Code

(CPT/HCPCS)

(Modifier)

Additional Procedure Code

(CPT/HCPCS)

(Modifier)

End Date OR Discharge Date

(MMDDYYYY)

Total Units/Visits/Days

36

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

794

Cardiac
Rehab

422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
410 Observation

997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health

333 BH Applied Behavioral Analysis
512 BH Community Based Services
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

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.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible as the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 07 28 2022

ES-PAF-1418

04/25/2025 11:03AM (GMT-05:00)