Amerigroup

Medicaid

https://provider.amerigroup.com

Prior Authorization Request Form

Amerigroup prior authorization: **800-454-3730** (phone); **800-964-3627** (fax).
To prevent delay in processing your request, please fill out form in its entirety with all applicable information.

Today's date:		**Provider return fax:**	
Member information			
First name:		Last name:		Date of Birth:	
Amerigroup member ID:		Contact phone:	
Address:		City, State ZIP code:	
Addition member information:			
Referring provider	**Participating: ☐**	**Nonparticipating: ☐**	
Full name:		NPI:	
Specialty:		Provider ID:	
Tax ID number (TIN):		Office contact name:	
Office phone:		Office fax:	
Address:		City, State ZIP code:	
Servicing provider	**Participating: ☐**	**Nonparticipating: ☐**	
Full name:		NPI:	
Specialty:		Provider ID:	
Tax ID number (TIN):		Office contact name:	
Office phone:		Office fax:	
Address:		City, State ZIP code:	
Servicing facility	**Participating: ☐**	**Nonparticipating: ☐**	
Name:			
NPI:		Provider ID:	
Tax ID number (TIN):		Facility contact name:	
Facility phone:		Facility fax:	
Address:		City, State ZIP code:	
Requested service (for type of service, check all that apply)		**Date/date range of service:**	
ICD-10 code(s):			
CPT® code(s) (include requested units/visits):			
Modifier(s):			
Type of service:	☐ Outpatient ☐ Planned inpatient ☐ Emergent inpatient ☐ Skilled nursing facility ☐ Long-term services & supports/long-term care ☐ Home health ☐ Durable medical equipment ☐ Diagnostic study ☐ Hospice ☐ Office visit ☐ Personal care services ☐ Other: ________________________		
Place of service:	☐ Hospital ☐ Ambulatory surgery center ☐ Office ☐ Home ☐ Independent lab ☐ Nursing facility ☐ Other: ____		
Additional information:			

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Amerigroup, please provide the authorization number with your submission in the Additional Information section.

Emergent – use for **all** nonelective **inpatient** admissions only, when provider indicates that the admission was urgent, emergent or expedited (for admission on same day).

Urgent – use for **outpatient** services only, when provider indicates that the service is urgent, emergent or expedited.