Ambetter Health Hospital HH/DME Discharge Requirements

1.) All highlighted areas shown below in the Outpatient Prior Authorization Form (PDF) must be completed. Then fax it to the **Discharge Only Durable Medical Equipment (DME)/Home Health (HH) Fax line: 1-833-422-1462**

   a. The Outpatient Authorization Form (PDF) is located at AmbetterHealth.com/flprovider under Medical Management —> Outpatient Prior Authorization Form (PDF).

   b. Fax the Outpatient Authorization Form to this number or **the request will be delayed**: **1-833-422-1462**

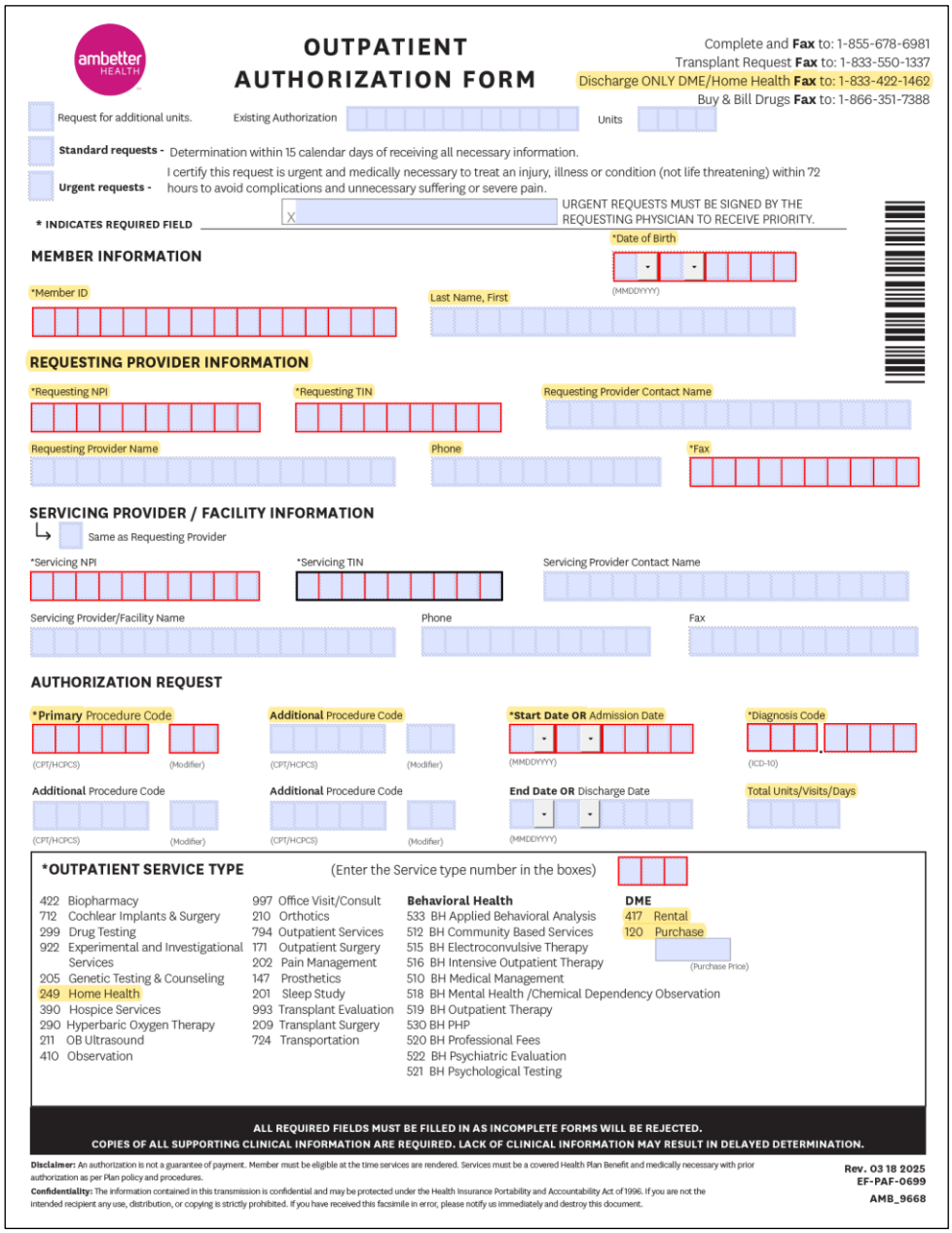
   c. If the requesting provider is a facility, put facility information in the **REQUESTING PROVIDER INFORMATION** field. Do not put hospitalist information in this field**. Provider name, phone and fax numbers must be filled in.**

   d. If staffing is needed for HH services, put SPHH in the **SERVICING PROVIDER INFORMATION** field. If staffing is needed for DME services, put SPDM in the **SERVICING PROVIDER INFORMATION** field.

   e. Put needed CPT/HCPCS codes in the Procedure code area. **Ambetter Health WILL NOT assign CPT/HCPCS codes**.

   f. Enter estimated **Start Date or Admission Date** with Diagnosis Code.

   g. Enter one of these service types: 249-Home health, 417 DME Rental, 120-DME Purchase under Outpatient Service Type.



ambetter HEALTH

OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 1-855-678-6981
Transplant Request **Fax** to: 1-833-550-1337
Discharge ONLY DME/Home Health **Fax** to: 1-833-422-1462
Buy & Bill Drugs **Fax** to: 1-866-351-7388

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.

X URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Member ID | Last Name, First | *Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI | *Requesting TIN | Requesting Provider Contact Name
Requesting Provider Name | Phone | *Fax

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 (CPT/HCPCS) (Modifier) | Additional Procedure Code (CPT/HCPCS) (Modifier) | *Start Date OR Admission Date (MMDDYYYY) | *Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier) | Additional Procedure Code (CPT/HCPCS) (Modifier) | End Date OR Discharge Date (MMDDYYYY) | Total Units/Visits/Days

***OUTPATIENT SERVICE TYPE** (Enter the Service type number in the boxes)

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
211 OB Ultrasound
410 Observation
997 Office Visit/Consult
210 Orthotics
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health
533 BH Applied Behavioral Analysis
512 BH Community Based Services
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
522 BH Psychiatric Evaluation
521 BH Psychological Testing

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 at 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.

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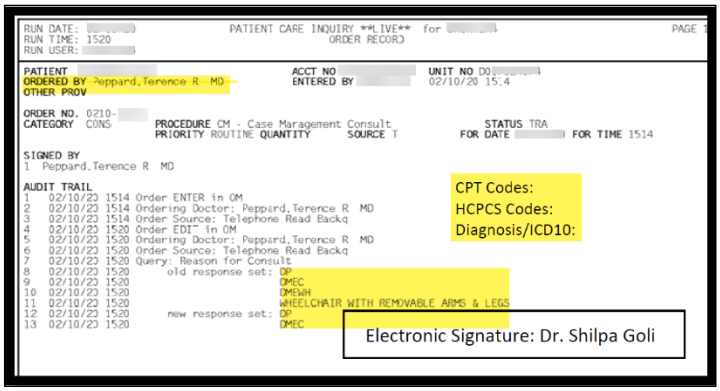
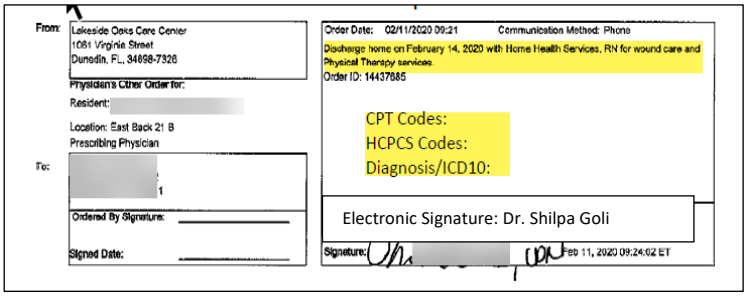
2.) Please include the REQUIRED minimum supporting information:
   a. Member/Patient Face Sheet
   b. Physician Signed Order for HH/DME
   c. DME and HH Orders
      i. Orders must be electronically signed or have a physical signature to be a valid order (signature must be on the same page as the order)
      ii. Must be dated and specify what HH or DME services the member requires
      iii. Order needs to contain a diagnosis with ICD10 code
      iv. Order needs to contain the pertinent CPT and HCPCS code(s)

DME Example Order:



Home Health Example Order:



   d. Clinical Documentation supporting the need for the requested DME/HH services.
      i. HH services for Physical, Occupational and/or Speech Therapy (PT, OT, ST) are processed by Evolent, an Ambetter Health vendor, instead of the health plan.
      ii. A DME request for assistive devices should contain evaluations from the appropriate ancillary providers/services detailing the need for the equipment
      iii. Most recent physician note(s)
      iv. Most recent physical information containing medications, treatments, and diagnosis
      v. For discharge request the admission report is needed