

Arkansas Authorization | Organizational Determination Request Form

Please return this completed form and supporting documentation by fax to:

All FEP/Exchange/Octave: **501-301-1996** | Standard Requests: **501-301-1994** | Urgent Requests: **501-301-1986**

By checking the Urgent Requests box or faxing to this number you certify that waiting could place the members life, health or ability to regain maximum function in jeopardy.

Contact information (for the person with whom we need to communicate about this request)

Contact name		Direct phone & Ext	
Email		Preferred fax for determination and correspondence	

Member information

First name		Middle initial	Last name	
Member ID number (including prefix)		Member date of birth (mm/dd/yyyy)		Phone
Member address		City	State	ZIP

Medical service/Procedure/Course of treatment/Device information

Authorization type (Please Check Only One Box)

If this is related to an existing authorization, please provide the authorization number: _____

Inpatient Outpatient

Drug, Under Medical benefit (any healthcare professional administered injection and/or infusion, CAR-T, or gene therapy billed under the medical benefit by provider, facility or specialty pharmacy)

Treatment type (Please Check Only One Box)

Medical	Home Health/ Skilled Nursing	Hospice Delivery	High-Tech Radiology Medical Oncology
Surgical	PT/OT/ST	Swing Bed	
Behavioral	DME	CT/PET Scans, MRIs	

Request type (Please Check Only One Box)

Initial Retrospective Concurrent Org Determination/Benefit Inquiry Only (for codes not on PA list)

Please note: The turnaround time for most OD/BI request is ten (10) business days.

Place of service (Please Check Only One Box)

School	Emergency Room	Hospice	Outpatient Hospital
Office	Ambulatory Surgery Center	Observation	Neuro Restorative Treatment Facility
Home	Skilled Nursing Facility	Rehabilitation Center	PT/OT/ST
Inpatient Facility		LTAC	

Requestor & Provider details

Requestor: Member Authorized Representative Provider Facility

Requesting provider

Provider name		Tax ID #	NPI #	Specialty
Group/Facility name			Group/Facility NPI #	Phone
Group/Facility address		City	State	ZIP

Servicing provider			
Provider name	Tax ID #	NPI #	Specialty
Group/Facility name	Group/Facility NPI #	Phone	Preferred Fax
Group/Facility address	City	State	ZIP

Diagnosis and procedure codes (if you have more than three codes for either section, just type the codes separated by commas)

Is this Craniofacial? Yes No

Diagnosis ICD (list primary first)		ICD Description			

HCP/PCS/CPT/CDT code	Code description	Medical reason	Start date	End date	Dose and frequency requested

Details

For inpatient admissions

Emergent Elective

Admission date & time	Expected discharge date & time	Days requested

Bed type

ICU Adult ICU Pediatric NICU Med Surg Adult Med Surg Pediatric Labor & Delivery

For procedures

Start date	End date	Unit type				Units requested
		Units	Days	Hours	Visits	

For medical benefit Rx

Start date	End date	Dose	Frequency

Route

Intramuscular (IM) Intravenous (IV) Subcutaneous (SC) Topical (TOP) Other _____

Other clinical information

Include/attach clinical and office notes, laboratory information, imaging reports, and any other necessary information to support this request. If this is a request for out-of-network services, please provide an explanation.

Instructions: Please fill out all applicable sections on all pages completely and legibly before faxing the form to the number listed. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request. Information contained in this form is Protected Health Information under HIPAA. If this request is for a prescription drug on the pharmacy benefit or for a transplant, please fill out the applicable form.

