SERVICE AUTHORIZATION REQUEST

Complete the following form and fax to Alaska Medicaid Fiscal Agent at 888-772-3632. Do not use this form to request Dental, Long Term Care, or Behavioral Health Services

Requesting Provider Information

1. Requesting Provider Alaska Medicaid ID
2. Contact Name and Phone Number
3. Requesting Provider Organization Name, Address, and Fax Number

Service Facility Information

4. Service Facility Alaska Medicaid ID
5. Service Facility Name

Member Information

6. Member Name (Last, First, MI)
7. Date of Birth
8. Alaska Medicaid Member ID
9. Age
10. Sex

Requested Services

11. Primary Diagnosis Code
12. Is Request Retroactive? ☐ Yes ☐ No
13. Date(s) of Service _____ to _____
14. Diagnosis and Medical Justification
(Attach any supporting documentation as needed)

For Alaska Medicaid Fiscal Agent Use Only

21. Your request is:
☐ Approved as requested
☐ Approved as modified (Items marked as Authorized may be claimed)

22. _____
Authorization Number

23. _____
From Date To Date

☐ Denied

24. Authorizing Agent
25. Date

26. Comments/Explanation

15. Procedure / Drug Code	16. MOD	17. Specific Services Requested	18. Unit/Qty	19. Charges	27. Authorized Yes	27. Authorized No	28. Approved Unit/Qty	29. Approved Amount

20. To the best of my knowledge, the above information is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Authorized Signature _____ Title _____ Date _____

Authorization does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

If you have received this in error, please mail to: Alaska Medicaid Fiscal Agent, PO Box 240808, Anchorage, AK 99524-0808.

Rev. 03/17/2023

SERVICE AUTHORIZATION REQUEST INSTRUCTIONS

Submission Requirements: This Service Authorization (SA) request must be completed to request services and must bear the signature of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medicaid program requirements. **Submit all Service Authorization requests directly to Alaska Medicaid Fiscal Agent**, by fax at 888.772.3632.

Requesting Provider Information

1. **Requesting Provider Alaska Medicaid ID:** Enter the requesting provider's Alaska Medicaid ID number.
2. **Requesting Provider Contact Name and Phone Number:** Enter the name and phone number of the person Alaska Medicaid Fiscal Agent or DHS staff should contact regarding the authorization request.
3. **Requesting Provider Organization Name, Address, and Fax Number:** Enter the requesting provider's organization name, address, and fax number.

Service Facility Information

4. **Service Facility Alaska Medicaid ID:** Enter the Alaska Medicaid ID of the facility where the service will be or was rendered.
5. **Service Facility Name:** Enter the name of the facility where the service will be or was rendered.

Member Information

6. **Member Name (Last, First, MI):** Enter the member's last name, first name, and middle initial.
7. **Date of Birth:** Enter the member's date of birth.
8. **Alaska Medicaid Member ID:** Enter the member's Alaska Medicaid ID number.
9. **Age:** Enter the member's age.
10. **Sex:** Select the member's gender.

Requested Services

11. **Primary Diagnosis Code:** Enter the primary diagnosis code applicable for the requested services.
12. **Is Request Retroactive?:** Check 'Yes' or 'No'.
13. **Date(s) of Service:** Enter the date(s) of service that the requested services are scheduled. **Note:** If request is retroactive, enter the date of service that requested services were rendered.
14. **Diagnosis and Medical Justification:** Enter the diagnosis and the medical justification for the services requested. Attach additional documentation as needed.
15. **Procedure Code:** Enter the corresponding procedure code for the service requested in box 17.
16. **MOD:** Enter any applicable modifier codes for the requested procedure.
17. **Specific Services Requested:** Enter the description of the requested service.
18. **Unit/Qty:** Enter the unit(s)/quantity of the service performed.
19. **Charges:** Enter the total charges for the requested service.
20. **Authorized Signature:** Enter signature and title for the professional submitting the service authorization request. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medicaid program requirements.
21. – 29. **For Alaska Medicaid Fiscal Agent Use Only:** Any information in these boxes may cause the request to become invalid.

Authorization does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services. **If you have received this in error, please mail to:** Alaska Medicaid Fiscal Agent, PO Box 240808, Anchorage, AK 99524-0808.