SUPERIOR HEALTH PLAN
REQUEST FOR AUTHORIZATION
USE THIS FORM INSTEAD OF CALLING
Please fax to: 800-690-7030

PROVIDER / FACILITY NAME LIFE AMBULANCE SERVICE INC. **# Pgs** _____

Contact Name _____ **Phone Number** 915-877-3155 EXT.107 **Fax #** 915-877-2234

Insurance Type ☒ Medicaid ☐ CHIP ☐ SSI ☐ STAR + PLUS ☐ Other _____

Type of Request ☐ Admission I/P ☐ Outpatient Services (list CPTs) ☐ Office ☐ 23 hr OBS
☐ Emergency ☐ Urgent ☐ Routine ☐ Out of Network ☐ Notification Only

* Patient Name _____ Med Rec # _____ Room # _____
* Patient ID Number _____ * Pt DOB _____ UR #

NPI #1861477762 ☒ Provider TPI # 088211001 ☐ Facility TPI # _____

Tax ID # ☒ Provider Tax ID # 751962356 ☐ Facility Tax ID # _____

Address _____

Admission Date / Date of Service _____ Admitting Diagnosis _____

Admitting DX codes _____

* Physician Name _____ Phys. Phone # _____

Outpatient Services * Place of service: _____ * Dates of Service: _____

☐ DME (description) _____ Is rent to purchase

☐ PT ☐ OT ☐ ST ☒ Other CPT Codes:

AMBULANCE TRANSFER
A0428- BLS NON EMERG SVC. -
A0425 - MILEAGE -
A0422 - OXYGEN -
A0382 - SUPPLIES -

Delivery Info (if applicable)

Type of Delivery ☐ Vaginal ☐ C-Section Newborn DOB _____

Baby's MRN # Weight _____ Grams _____ APGAR _____ Gest Age _____
☐ Nursery ☐ NICU Sick Baby DX:
☐ Name of Admitting Physician:

* **Clinical Information for Medical Necessity Attached and Faxed:** ☐ Yes ☐ No
Other Comments/ Clinical History/Failed O/P Therapy, etc. _____

Superior Health Plan Determination: *(To be faxed back to provider)*

☐ Approved as requested	Referral Specialist _____
Auth #	Exp Date: ☐ Dates / Days Authorized

☐ Medical Director Review Pending ☐ Denied ☐ Pending Add'l Info ☐ No Referral Needed

☐ Approved with Modifications _____