Prior Authorization Request

Prior authorization is the approval of medically necessary services for members
Prior authorization applies to the requested service(s) only and does not guarantee payment, nor does it guarantee the amount billed will be the amount reimbursed. The member must be Medicaid eligible and a member on the date of service or date

See below for instructions.

I. General information	
1. Member name:	
2. DOB:	
3. Address (Street, City, State ZIP):	
4. Phone number:	
5. Medicaid ID/subscriber ID:	
6. Diagnosis code:	
7. Diagnosis description:	
8. Name, NPI, and address of facility where services are to be rendered, if other than home or office:	

II. Service information						
9. Ref. NO.	10. Procedure code	11. Place of Service	12. From	13.Through	14. Description of service/ item	15. Qty or units
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

16. Detailed explanation of medical necessity for services/equipment/procedure/prosthesis. (Attach additional pages if necessary.):

III. Provider			
17. Provider name:		18. Telephone:	
19. Address:			
20. NPI:		21. Fax:	

IV. Practitioner			
22. Name:		23. Telephone:	
24. Address:			
25. Fax:			

V. Prior authorization request form completed by	
26. Contact name:	
27. Phone number:	
28. Fax number:	
VI. For plan use only	
Denial reason(s): Refer to field 9 above by reference numbers (Ref. NO.):	
If approved: Services authorized to begin	