

PRIOR AUTHORIZATION REQUEST

FOR DMA USE ONLY

Include this number on all claim Forms----->

PRIOR AUTHORIZATION NO

1. Member Name (Last, First, Middle Initial)					2. Medicaid ID No.				
3. Birth date		4. Sex	5. Address			Nursing Home <input type="checkbox"/> YES <input type="checkbox"/> NO		6. Telephone (Area Code/Number)	
7. Prescribing Physician/ Practitioner Name and Address					10. Provider of Services(s) Name And Address				
8. Medicaid Provider Number			9. Telephone (Area Code/Number)		8. Medicaid Provider Number			9. Telephone (Area Code/Number)	
<input type="checkbox"/> HOME HEALTH <input type="checkbox"/> PODIATRIST <input type="checkbox"/> OPTOMERIST <input type="checkbox"/> PHYSICAN <input type="checkbox"/> PSYCHOLOGIST <input type="checkbox"/> DME/OP <input type="checkbox"/> DDS <input type="checkbox"/> PHARMACY					DEPT USE ONLY				
13. Authorization Period From: Through:			14. Description of Service(s) Required			15. Rec. Type		16. Ctgy. of Service	
17. Primary Diagnosis Requiring Service(s)							18. ICD 9 CM		
19. Justification and Circumstances for Required Service(s) (Use separate page if necessary)									

STATEMENT OF SERVICE(S)

LINE NO. 20	21. Description of Procedures, Drugs, Equipment, or Other Services	22. Procedure/ Drug Code	23. Requested of Estimated Price Per unit	24. Bill Units	25. Months of Units of Service	26. Units per Claim		27. Max. units per month
						Max.	Min.	
1								
2								
3								
4								
5								
6								
7								
8								

			28. PROVIDERS SIGNATURE			29. Date Submitted		
30. REQUEST <input type="checkbox"/> Approved <input type="checkbox"/> Approved As Amended <input type="checkbox"/> Denied <input type="checkbox"/> Pending /Additional Information				31. DMA SIGNATURE			32. DATE APPROVED / /	
33. Explanation to Provider								

**Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program*

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