

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)		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					
13. Authorization Period From: Through:		14. Description of Service(s) Required		15. Rec. Type	
				16. Ctg. 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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