

MEDICAID SUPPLEMENTAL INFORMATION PRIOR AUTHORIZATION FORM

MEMBER INFORMATION

Medicaid/Member ID Last Name, First Date of Birth

(MMDDYYYY)

Requesting Provider Address

(Street Address) (City) (State) (Zip Code)

Servicing Provider Address

(Street Address) (City) (State) (Zip Code)

ADDITIONAL DIAGNOSIS CODES

Diagnosis Code Diagnosis Code Diagnosis Code

(ICD-10) (ICD-10) (ICD-10)

Diagnosis Code Diagnosis Code Diagnosis Code

(ICD-10) (ICD-10) (ICD-10)

ADDITIONAL PROCEDURE CODES

Procedure Code Total Units/Visits/Days Procedure Code Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

Procedure Code Total Units/Visits/Days Procedure Code Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

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(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

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Procedure Code Total Units/Visits/Days Procedure Code Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible when services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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