MEDICAID SUPPLEMENTAL INFORMATION
PRIOR AUTHORIZATION FORM

Sheet ___ of ___

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 (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

Diagnosis Code (ICD-10)

ADDITIONAL PROCEDURE CODES

Procedure Code (CPT/HCPCS)	(Modifier)	Total Units/Visits/Days	Procedure Code (CPT/HCPCS)	(Modifier)	Total Units/Visits/Days

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.