



**PREAUTHORIZATION REQUEST FORM
PHYSICIAN SERVICES**

SECTION I- PATIENT INFORMATION

MEDICAID NUMBER (11 DIGIT)		TELEPHONE
NAME (LAST, FIRST, MI)		ADDRESS
DOB	SEX	

SECTION II- PROVIDER INFORMATION

PAY TO PROVIDER # (9 DIGIT)		RENDERING PROVIDER # (9 DIGIT)	
NAME		NAME	
ADDRESS		ADDRESS	
TELEPHONE		TELEPHONE	
PROVIDER SIGNATURE			
Contact information for person completing this form:			
NAME		EMAIL	PHONE

SECTION III- PREAUTHORIZATION INFORMATION

REQUEST DATE	DATES OF SERVICES: FROM	THRU
DIAGNOSIS CODES: 1.	2.	3.

SECTION IV- PREAUTHORIZATION LINE ITEM INFORMATION

CODE	MOD 1	MOD 2	REQUESTED UNITS	DEPARTMENT USE ONLY

SECTION V- SPECIFIC PROGRAM PREAUTHORIZATION INFORMATION

PLEASE ATTACH CORRESPONDENCE WHICH INCLUDES BUT IS NOT LIMITED TO THE FOLLOWING:

- A. COMPLETE NARRATIVE JUSTIFICATION FOR PROCEDURE(S)
- B. BRIEF HISTORY AND PHYSICAL EXAMINATION
- C. RESULT OF PERTINENT ANCILLARY STUDIES IF APPLICABLE
- D. PERTINENT MEDICAL EVALUATIONS AND CONSULTATIONS IF APPLICABLE

PREAUTHORIZATION NUMBER (DEPARTMENT USE ONLY)

SUBMISSION INSTRUCTIONS:

Fax completed form and all required attachments to:
1-410-767-6034.