Children's Mercy
PEDIATRIC CARE NETWORK

Prior Authorization

Please provide all necessary information. Submitting requests that are illegible or with sections left blank, or requests missing necessary clinical, may delay the review process. *Services may be requested when 75% of authorized units have been used &/or 14 days in advance of the authorization expiration date.*

Section I -- Submission

Requestor Name: _____ Phone: _____ Fax: _____

Email: _____ Date: _____

Section II -- General Information

Review Type: ☐ Non-Urgent (TAT 36 hrs (including 1 business day)) ☐ Urgent (TAT 24 hrs) (The member's life, health or safety could be jeopardized or adverse health consequences could occur without the requested service.)

For urgent requests outside of normal business hours, on weekends, or holidays please call PCN at the below toll free numbers to ensure timely processing of your request.

Request Type:

- ☐ Initial Request
- ☐ Extension/Renewal/Amendment
- ☐ Inpatient Notification

Clinical Reason for Urgency: _____

Prev. Auth #: _____

Section III -- Patient Information

Name: _____ Phone: _____ DOB: _____

Subscriber Name (if different): _____ Member or Medicaid ID #: _____

Primary Care Provider Name: _____ Phone: _____ Fax: _____

Section IV -- Provider Information

Requesting/Ordering Provider

Name: _____

NPI #: _____ TIN: _____

Phone: _____ Fax: _____

Contact Name: _____

Phone: _____

Provider of Service or Facility

Name: _____

NPI #: _____ TIN: _____

Phone: _____ Fax: _____

State Medicaid ID # _____

Please note that claims may be denied if you are not registered with the state Medicaid agency.

Section V -- Services Requested (with CPT/HCPCS or Rev Code) and Supporting Diagnoses (with ICD Code)

Planned Services or Procedure	Units/Quantity Requested	with CPT/HCPCS or Rev Code	Start Date	End Date	Diagnosis Description	ICD-10 Code

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) Quantity / Units _____

Equipment / Supplies (include any HCPCS Codes): _____ Duration: _____

Notes: