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.
Initial requests for authorization may be requested up to 120 days in advance of the initial date of service. Ongoing 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/ Retroactive
TAT 36 hrs (including 1 business day)

❑ Urgent
TAT 24 hrs

The ordering provider has certified via signed order that the member's life, health or safety could be jeopardized or adverse health consequences could occur without the requested service being completed within the next 24 hours. **Please note: Urgent requests must include clinical reason for urgency to receive priority.** 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 Future Request
❑ Extension/Renewal/Amendment
❑ Inpatient Notification or Planned Admission Request
❑ Retroactive

Clinical Reason for Urgency: _____

Prev. Auth #: _____

Have you received a claim denial for this retroactive request? ❑ Yes ❑ No

If a claim denial has been issued, providers are required to first file an appeal through the health plan claim reconsideration and appeals process.

Section III -- Patient Information

Name: _____ Phone: _____ DOB: _____

MRN (if inpatient): _____ Member or Medicaid ID #: _____

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

Section IV -- Provider Information

Requesting/Ordering Provider

❑ Current signed orders from the ordering provider or attending physician included

Name: _____

NPI #: _____ TIN: _____

Phone: _____ Fax: _____

Contact Name: _____

Phone: _____

Provider of Service or Facility (Billing)

❑ Participating ❑ Non-Participating*

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

Notes: Please include any specifics around total number of visits, duration/frequency, or volumes. Please note for DME if this is a purchase or rental.

*Service requests from non-participating providers must include clinical information and, if approved, these services will be paid per the applicable state Medicaid rates.