

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

Request Type: 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.

- 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: