**Submit fax request for Prior Authorization to 1-855-300-0082**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1. [ ]  Initial** | **[ ]  Continuation****PA #** | **[ ]  Change****PA #** | **[ ]  Cancel** | **\*REQUIRED\*****CONTACT NAME:** **\*CONTACT FAX:****CONTACT PHONE:** |
| 2**. Date of Request (mm/dd/yyyy)**    /  /     | 3**. Review Type (check one if applicable)**[ ]  Prior Authorization[ ]  Retrospective Review (Date notified of retrospective eligibility   /  /    ) |
| 4. **Member Medicaid ID Number** (10-digit Number):       | 5. **Member Last Name**:       | 6. **Member First Name:**  | 7. **Date of Birth** (mm/dd/yyyy):   /  /     | 8. **Gender:**[ ]  Male[ ]  Female |
| *9.* **a***.* **NPI/Requesting Provider Name & ID Number:****b**. **9-digit Zip Code (Mandatory)** | 10.  **Diagnosis Codes: (enter up to 5) list primary first**1.       2.      3.       4.      5.       |
| 11**.**  **a**. **NPI/Rendering FACILITY ID Number:**        **b**. **9-digit Zip Code**       ***(Mandatory)*** | 12**. Prior Auth Service Type: \*REQUIRED\*** **START OF CARE DATE**    /  /    [ ]  **IOP S9480** **Number of Days** \_\_\_\_\_ up to 30 [ ]  **PHP H0035** **Number of Days** \_\_\_\_\_ up to 30  |  |
| 13**. Required Documentation attached:****\_\_\_\_ Physician’s order for IOP or PHP****\_\_\_\_ documentation supporting members condition that outlines escalation of need for more intensive service** |

**\*Complete all sections of the form\***