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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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\***