Prior Authorization Request Form

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be eligible for NC Medicaid or NC Health Choice on the date of service or the date the equipment or prosthesis is received by the beneficiary. **See second page for instructions.**

I. General information

1.	2. Name (last, first, M.I.):	3. Date of birth:
4. Address (street, city, state, ZIP code):		
5. NC Medicaid ID number:	6. Diagnosis code:	
7. Diagnosis description:		
8. Name and address of facility where services are to be rendered, if other than home or office:		

II. Service information

9. Ref. #	10. Procedure code	11. From	12. Through	13. Description of service/item	14. Qty. or units	For Plan Use Only: Approved	Denied	Amount allowed if priced by report
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								

15. Detailed explanation of medical necessity for services, equipment, procedures or prostheses (attach additional pages if necessary):

III. Provider

16. Provider name:
17. Address:
18. Fax number:

IV. Prescribing or performing provider

19. Name:	20. Phone:
21. Address:	
By submitting this form, the provider identified in this Section IV certifies that the information given in Sections I through III of this form are true, accurate and complete.	

V. For plan use only

Denial reasons (refer to field 16 above by reference numbers [ref. #]):

If approved: Services authorized to begin	Date:	Reviewed by signature:

Instructions for completion

I. General information (to be completed by the provider requesting the prior authorization)

1. Leave blank.
2. Beneficiary's name — Enter the beneficiary's name as it appears on the NC Medicaid identification card. Enter the beneficiary's current address.
3. Date of birth — Enter the beneficiary's date of birth.
4. Address — Enter the beneficiary's address, city, state, and ZIP code.
5. NC Medicaid number — Enter the beneficiary's NC Medicaid identification number as shown on the NC Medicaid identification card or county letter of eligibility.
6. Diagnosis code — Enter the diagnosis codes.
7. Diagnosis description — Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
8. Name and address of the facility where services are to be rendered, if service is to be provided at a location other than the home or office.

II. Service information

9. Ref. # (reference number) — Enter the unique designator (1 – 12) identifying each separate line on the request.
10. Procedure code — Enter the procedure codes for the services being requested.
11. From — Enter the date that services will begin if authorization is approved (MM/DD/YY format).
12. Through — Enter the date services will terminate if authorization is approved (MM/DD/YY format).
13. Description of service/item — Enter a specific description of the service or item being requested.
14. Quantity or units — Enter the quantity or units of the service or item being requested.
15. Detailed explanation of medical necessity of the services, equipment, procedures, or prostheses. Attach additional pages as necessary.

    Do not use another Prior Authorization Request Form.

III. Provider requesting prior authorization

16. Provider name — Enter the requested provider's information. If a clinic or group practice, also complete section IV.
17. Address — Enter the complete mailing address in this field.
18. Fax number — Enter the requested provider's fax number, including the area code.

IV. Prescribing or performing provider

This section must be completed for services which require a prescription such as durable medical equipment or physical therapy, for services which will be prescribed by a provider that require prior authorization, or when the provider in section IV is a clinic or group practice. Check your provider manual for additional instructions.

19. Name — Enter the name of the prescribing or performing provider.
20. Phone number — Enter the prescribing or performing provider's phone number, including area code.
21. Address — Enter the address, city, state and ZIP code.

V. For plan use only

Approval or denial for each line will be indicated in the boxes to the right of Section III. Also in this box the consultant will indicate allowed amount, if the procedure requires manual pricing. At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 through 12). The consultant will sign or initial the form.

Fax this form to: **1-833-893-2262** or call Utilization Management Prior Authorization: **1-833-900-2262**.
Insert date (MM/DD/YYYY): ____ / ____ / ______