PRIOR AUTHORIZATION REQUEST FOR ADDITIONAL VISITS

| CLIENT LAST NAME: | |  | | | | CLIENT FIRST NAME: | | |  | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT MAILING ADDRESS: | | | |  | | | | | | | | | |
| CLIENT PHONE: | **(     )-     -** | | | | | MEDICAID NUMBER: | | | |  | | DOB: |  |
| HEALTH CONDITION, HEALTH RISK OR  HIGH-RISK CONDITION: | | |  | | | | | | | | FOR PREGNANT WOMAN,  DATE OF DELIVERY OR  EXPECTED DATE OF DELIVERY: | |  |
|  | | | | | | | | | | | | | |
| **Specific Needs RElated to the Health Condition/Health Risk/High-risk condition:**  In each box, describe one specific need and intervention. If indicated, list and describe any barriers or problems related to accessing the specific need. Document if this need was previously identified on previous request. (Only document up to three specific needs). | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | |
| **Additional Visits Requested**  Face-to-Face follow-up G9012, U5, TS, # Requested \_\_\_\_\_\_\_\_\_\_\_\_  Telephonic follow-up G9012, TS, # Requested \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **BY SUBMITTING THIS REQUEST, YOU ARE CONFIRMING THAT ALL PREVIOUSLY AUTHORIZED VISITS HAVE BEEN COMPLETED.**  DATE OF LAST VISIT: **/     /** | | | | | | | | | | | | | |
| THE CLIENT IS A:  CHILD (AGE 0 – 20) WITH A HEALTH CONDITION OR HEALTH RISK  PREGNANT WOMAN (OF ANY AGE) WITH A HIGH-RISK CONDITION | | | | | | | | | | | | | |
| **By completing and submitting this requesT:**   * I attest that the client/parent/guardian has confirmed the documented needs, was informed of the choice of case management providers, and desires case management services. * I confirm that the information is true and correct to the best of my knowledge. * understand that Prior Authorization is a condition of reimbursement for services and not a guarantee of payment. | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | |
| CASE MANAGER SIGNATURE | | | | | | | DATE | | | | | | |
|  | | | | | | |  | | | | | | |
| CASE MANAGER NAME | | | | | | | case manager TPI number (blank if fqhc) | | | | | | |
|  | | | | | | |  | | | | | | |
| PROVIDER (COMPLETE NAME OF GROUP) | | | | | | | Provider TPI NUMBER (group or fqhc) | | | | | | |
|  | | | | | | | |  | | | | | |
| GROUP NPI | | | | | | | | INDIVIDUAL NPI | | | | | |
| **(     )      -** | | | | | **(     )      -** | | |  | | | | | |
| PROVIDER PHONE NUMBER | | | | | PROVIDER FAX NUMBER | | | PROVIDER EMAIL | | | | | |

**NOTE:** PROGRAM STAFF MAY REQUEST ADDITIONAL INFORMATION TO SUPPORT REQUEST.

**Please fax Request to DHP Case and Disease Management at 1-866-704-9824**

**DHP Case and Disease Management toll-free phone number is 1-877-222-2759**