## Initial Prior Authorization Request

| CLIENT LAST NAME: | | | | | CLIENT FIRST NAME: | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MEDICAID NUMBER: | | MEDICAID TYPE:  Pending Medicaid Traditional Medicaid  Medicaid Managed Care | | | | | | | | | | |
| CLIENT DATE OF BIRTH: | | MALE  FEMALE | | | | | | LANGUAGE PREFERENCE: | | | | |
| PARENT/GUARDIAN: | | | | HOME PHONE: | | | | | ALTERNATE PHONE: | | | |
| MAILING ADDRESS: | | | | CITY: | | | | | | ZIP: | | |
| PCP: | | | | | | | | | | | | |
| REFERRAL DATE: | | REFERRAL SOURCE:  Agency: Name of contact: Phone # | | | | | | | | | | |
| **Health Condition, Health Risk OR High-Risk CONDITION**: Document health condition/s or describe specific health risk/s, symptom/s, developmental delay/s and/or behaviors. Additionally, describe how health condition, health risk, symptoms, developmental delays and/or behaviors impacts level of functioning. For a Pregnant woman, describe high-risk condition and describe how high-risk condition impacts level of functioning. | | | | | | | | | | | | |
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| **Psychosocial Factor**: If indicated, describe any specific high-risk psychosocial factors that are impacting the health condition, health risk, or high-risk condition. | | | | | | | | | | | | |
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| THE CLIENT IS A: | | | | | | | | | | | | |
| Child (age 0 – 20) with health condition or health risk | | | | Pregnant Woman (of any age) with a HIGH-RISK Condition 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. (Only document up to three specific needs) | | | | | | | | | | | | |
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| **Visits Requested:**  COMPREHENSIVE  FACE TO FACE FOLLOW-UP TWO (Need must be justified with documentation)  TELEPHONIC FOLLOW-UP TWO (Need must be justified with documentation) | | | | | | | | | | | | |
| **By completing and submitting this requesT:**   * I attest that the client/parent/guardian has confirmed the documented needs, was informed of 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 * i understand that Prior Authorization is a condition of reimbursement for services and not a guarantee of payment. | | | | | | | | | | | | |
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| signature of person completing form | | | printed name of person completing form | | | | | | | | date Intake Completed | |
|  | | | | | |  | | | | | | |
| case manager name | | | | | | case manager tpi number (blank if fqhc) | | | | | | |
|  | | | | | |  | | | | | |  |
| case Management provider (complete name of agency) | | | | | | provider tpi number (group or fqhc tpi) | | | | | |  |
|  |  | | | | | |  | | | | | |
| GROUP NPI |  | | | | | | INDIVIDUAL NPI | | | | | |
| (     )     - | (     )     - | | | | | |  | | | | | |
| phone number | fax number | | | | | | e-mail | | | | | |

**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**