## 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. |
|  |
| **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**