MEDICAID SUPPLEMENTAL INFORMATION

PRIOR AUTHORIZATION FORM

Sheet ___ of ___

Medicaid/Member ID

Last Name, First

Date of Birth
(MMDDYYYY)

Requesting Provider Address
(Street Address) (City) (State) (Zip Code)

Servicing Provider Address
(Street Address) (City) (State) (Zip Code)

ADDITIONAL DIAGNOSIS

Diagnosis Code (ICD-10) | Diagnosis (ICD-10) | Diagnosis (ICD-10)

Diagnosis Code (ICD-10) | Diagnosis (ICD-10) | Diagnosis (ICD-10)

ADDITIONAL PROCEDURE CODES

Procedure Code (CPT/HCPCS) (Modifier) | Total Units/Visits/ | Procedure Code (CPT/HCPCS) (Modifier) | Total Units/Visits/

Procedure Code (CPT/HCPCS) (Modifier) | Total Units/Visits/ | Procedure Code (CPT/HCPCS) (Modifier) | Total Units/Visits/

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ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION