

## Notice of Decision for Prior Authorization Request

Date:

PROVIDER NAME  
STREET ADDRESS  
CITY, STATE, ZIP CODE

Member Name:  
Medicaid ID#:  
Date of Birth:

Status: **Denied**  
Date of Service:                      to

Denied Service(s):

Procedure, Supply, or Drug to be provided	Code, HCPCS, or CPT	Denied Units

**Important Note:** In evaluating requests for prior authorization, the need for treatment will be considered from the standpoint of medical necessity only. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility prior to service by calling the ELVS line at 1-800-338-7752 (locally at 515-323-9639) or by accessing the Web Portal. Contact Provider Services at 800-338-7909 or (locally) 256-4609 for assistance in accessing the Web Portal.

**Reason for denial of requested service(s), rule reference, or additional comments**

You have the right to appeal. See the following correspondence to find out how to file an appeal.

Sincerely,  
QIO Medical Services Unit  
470-5605 (3/20)