

# MEDICAID SUPPLEMENTAL INFORMATION PRIOR AUTHORIZATION FORM

## MEMBER INFORMATION

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 Diagnosis Diagnosis

(ICD-10) (ICD-10) (ICD-10)

Diagnosis Code Diagnosis Diagnosis

(ICD-10) (ICD-10) (ICD-10)

## ADDITIONAL PROCEDURE CODES

Procedure Code Total Units/Visits/ Procedure Code Total Units/Visits/

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

Procedure Code Total Units/Visits/ Procedure Code Total Units/Visits/

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

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Procedure Code Total Units/Visits/ Procedure Code Total Units/Visits/

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier)

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

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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