

<b>ACS USE ONLY</b>
PA No.: _____

Urgent Request       Extension Request       New Request

**REQUEST FOR MEDICAL AUTHORIZATION**

**Check only ONE – Different Types of Services Must Be Requested on Separate 1144 Forms.**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> BH – Psych. Testing/ & Detox | <input type="checkbox"/> GT – Transportation               | <input type="checkbox"/> LT – Long Term Care       | <input type="checkbox"/> OS- Out of State Services    |
| <input type="checkbox"/> DE – Dental                  | <input type="checkbox"/> HE- Home Health                   | <input type="checkbox"/> MD- Professional Services | <input type="checkbox"/> RE – Rehabilitation Services |
| <input type="checkbox"/> DM – Appl./DME/ Supplies     | <input type="checkbox"/> LN – Sign Language Interpretation | <input type="checkbox"/> OP – Outpatient Facility  | <input type="checkbox"/> SR – Hospice                 |

\*\*\* ***This Form should NOT be used for: Incontinence Supplies, EPSDT Medically Fragile Services and Drugs.*** \*\*\*

**NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS.** Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant.

**PLEASE PRINT INFORMATION CLEARLY**

Medicaid Identification Number:	Patient Name (Last, First, M.I.):	Gender [ ] M [ ] F	Date of Birth ____/____/____
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Medicare Coverage? [ ] Yes [ ] No Is Patient receiving Medicare Home Health Benefits? [ ] Yes [ ] No	Currently at: [ ] Home [ ] SNF/ICF/ICF-MR Facility [ ] Other: _____ Patient Mailing Address (St., Apt. No., City, Zip Code) _____ name
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Physician Section			Supplier Section (Circle Rent or Repair)			
Service Description	Procedure Code	QTY	Purchase Price	Rent/Repair	Period Requested From To	
1						
2						
3						
4						
5						

<b>Physician Section</b>	<b>Physician/ Supplier Comments</b>
Diagnosis(es):	
Justification:	
Attachment: [ ] Yes [ ] No	If applicable: Serial No.: _____ MSRP Attached: [ ] Yes [ ] No

**I certify that the items and quantities above are prescribed by the physician indicated below and will be provided by the supplier.**

Physician/Provider Signature:	Date:	
Print Physician/ Provider Name:	Provider Number:	
Print Contact Name: (if different from Physician)	Telephone Number:	Fax Number:

**I certify that the items and quantities above are prescribed by the physician indicated above and will be provided by the supplier.**

Supplier Signature:	Date:	
Print Supplier/ Company Name:	Supplier Number:	
Print Contact Name:	Telephone Number:	Fax Number:

To be completed by Medicaid (A= Approved P= Pended D= Denied R= Revoked)						
Code Line	Modifier(s)	QTY	Auth. Code	Approved Period From To		Consultant Comments:
1						
2						
3						
4						
5						