

REQUEST FOR MEDICAL AUTHORIZATION

Check only One – Different Types of Services Must Be Requested on Separate 1144B Forms. Home Infusion PA Non-home infusion (Medication only) PA

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.

¹ Medicaid ID Number		² Recipient's Name (Last, First, M.I.)			³ Gender [] M [] F		⁴ Date of Birth / /		
⁵ Medicare Coverage? [] Yes [] No Is Patient receiving Medicare Home Health Benefits? [] Yes [] No		⁶ Currently at: [] Home [] Hospital [] SNF/ICF/ICF-MR Facility Recipient's Mailing Address (St., City, Zip Code)			⁷ Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT): [] Yes [] No				
Physician Section				Supplier Section (Circle Rent or Repair)					
⁸ NDC Number or Drug Name, Strength, Units, Global Code, or HCPCS code				⁹ QTY	¹⁰ Purchase Price		¹¹ Rent/Repair	¹² Period Requested	
1								From:	To:
2									
3									
4									
5									
Physician Section									
¹³ Diagnosis or ICD-9 code							¹⁴ BMI (for anorexians):		
¹⁵ Period Requested				¹⁶ Prognosis					
¹⁷ Justification (include history of previous treatment) ([] Attachment)									
¹⁸ Print Prescriber's Name/Mailing Address					¹⁹ Prescriber's Signature				
					²⁰ Prescriber's NPI				²¹ Date
					²² Telephone #				
					²³ Fax #		²⁴ Contact Name		
Supplier Section									
²⁵ Print Supplier's Name/Mailing Address					²⁶ Comments				
²⁷ Contact Name		²⁸ Telephone #		²⁹ Fax #					
³⁰ Supplier's Signature		³¹ Supplier's NPI		³² Date					