

REQUEST FOR PRIOR AUTHORIZATION OUT-OF-STATE MEDICAL TREATMENT

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

RECIPIENT INFORMATION

Recipient's Medicaid ID No.	Recipient's Name (Last, First, Middle)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (MM/DD/YYYY)		
Medicaid Eligibility Date	Medicare Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Insurance			
Attendant Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Reason For Attendant			Name of Attendant	
Date(s) of Service	Procedures/Services	Procedure Code	Quantity	Disposition	
1. ___/___/___ to ___/___/___	_____	_____	_____	_____	
2. ___/___/___ to ___/___/___	_____	_____	_____	_____	
3. ___/___/___ to ___/___/___	_____	_____	_____	_____	

Diagnosis

Reason For Out-Of-State Medical Treatment

REFERRING PROVIDER INFORMATION

Name of Referring Physician	Referring Provider ID No.	Referring Provider Phone No.
Contact Person At Office	Phone No.	Fax No.
Referring Physician Signature		Date

RENDERING PROVIDER INFORMATION

Name of Rendering Physician	State Medicaid Provider ID No.	Rendering Provider Phone No.
Mailing Address		
City	State	Zip Code
Contact Person At Office	Phone No.	Fax No.

***Rendering Physician, do you agree to accept Medicaid Payment as Full Payment:** Yes No

Services Provided In Hospital: Yes No If Yes, Name Of Hospital:

Contact Name Phone No.

THIS SECTION TO BE COMPLETED BY THE MED-QUEST DIVISION

Determination: <input type="checkbox"/> Approve <input type="checkbox"/> Not Approved <input type="checkbox"/> Incomplete	Airfare: <input type="checkbox"/> Yes <input type="checkbox"/> No	Attendant/Companion: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lodging: <input type="checkbox"/> Yes <input type="checkbox"/> No	Meals: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ground Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Comments

DHS Medical Consultant Signature

Date