Prior Authorization and Concurrent Review Request Form

www.amerihealthcaritasia.com

Fax completed form and all pertinent clinical information related to your request to:

Prior authorization fax number: **1-844-399-0478**

Inpatient and concurrent review fax number: **1-844-411-0605**

Please complete all appropriate fields.

Patient information
Patient Medicaid number:
Date of birth:
Patient name:
Address:
City/State/ZIP code:
Patient/Guardian phone:
PMP name:
PMP NPI:
PMP phone:
Ordering, prescribing or referring (OPR) provider information
OPR physician NPI#:

Medical diagnosis (ICD diagnostic code is required)					
Dx1		Dx2		Dx3	

Requesting provider information
Requesting provider NPI#:
Tax ID#:
Service location code:
Provider name:
Rendering provider information
Rendering provider NPI#:
Tax ID#:
Name:
Address:
City/State/ZIP code:
Phone:
Fax:
Preparer's information
Name:
Phone:
Fax:

Please check the requested assignment category below:

- ❑ DME
  - ❑ Purchased
  - ❑ Rented
- ❑ Home health
- ❑ Hospice
- ❑ Inpatient
- ❑ Observation
- ❑ Office visit
- ❑ Occupational therapy
- ❑ Outpatient
- ❑ Physical therapy
- ❑ Speech therapy
- ❑ Transportation
- ❑ Other

Service start date	Service end date	CPT/HCPS/Procedure/ Service codes	Requested service	Number of visits or units requested

Notes:_____

Please note: Your request **must** include medical documentation to be reviewed for medical necessity.

Signature of qualified practitioner:_____ Date:_____