NEW HAMPSHIRE MEDICAID

REQUEST FOR PRIOR AUTHORIZATION IN EXCESS OF SERVICE LIMITS

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: ____________________ **RECIPIENT DOB:** ____/____/____

RECIPIENT MEDICAID ID #: ____________________

PROVIDER INFORMATION

DATE OF REQUEST: ____/____/____ **CONTACT PERSON:** ____________________

PROVIDER NAME: ____________________ **NH MEDICAID PROVIDER #:** ____________________

ADDRESS: ____________________ **CITY/STATE/ZIP:** ____________________

TELEPHONE #: ____________________ **FAX #:** ____________________

DIAGNOSIS (written, not ICD-9) **PRIMARY:** ____________________

SECONDARY: ____________________

TYPE OF TREATMENT	PROCEDURE CODE	FREQUENCY OF TREATMENT	TOTAL # OF UNITS	DATES OF SERVICE	
				START	END

ANTICIPATED RESULT(S) OF PROVIDING THESE EXTRA SERVICES: (use additional paper as necessary)

CLINICAL INFORMATION:
Please attach physician's order and clinical notes supporting the medical necessity for the requested services, and providing goals and objectives, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

CERTIFICATION OF MEDICAL NECESSITY
(to be signed by the PCP or treating physician/ARNP)

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

____________________ ____________________
Signature **Date**

____________________ ____________________
Print Name/Title **Specialty (if applicable)**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

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