



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION FOR OUT OF STATE INPATIENT ADMISSION

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

RECIPIENT NAME: _____	RECIPIENT DATE OF BIRTH: ____/____/____
PLANNED DATE OF ADMISSION: ____/____/____	RECIPIENT MEDICAID ID: _____
ADMITTING PHYSICIAN: _____	ADMITTING DIAGNOSIS: _____
ADMITTING FACILITY/HOSPITAL: _____	PROCEDURE TO BE PERFORMED: _____

REFERRING PROVIDER INFORMATION

REFERRING PROVIDER NAME: _____	CONTACT PERSON #: _____
_____	NH MEDICAID PROVIDER #: _____
TELEPHONE #: _____	FAX #: _____

REASON FOR REFERRAL/PROCEDURE TO BE PERFORMED:

PAST RELEVANT HISTORY PURSUANT TO THIS ADMISSION:

EXPLAIN WHY THIS CARE CANNOT BE PROVIDED BY A NH HOSPITAL OR PROVIDER:

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

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

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

_____	_____
Signature	Date

Please print:

_____	_____
Name/Title	Specialty