CCP MEDICAL AUTHORIZATION REQUEST FORM

T19 MMA Fax requests (844) 806-0397 •T21 Fax requests (844) 806-0397
T19 MMA Questions (866) 209-5022 •T21 Questions (866) 202-1132
eINFOsource Provider Portal: https://cms.einfosource.med3000.com

One request per form - Separate approvals must be obtained for the facility and the provider.

Program: ☐ **Title XIX (T19 MMA-CMSN Plan)** ☐ **Title XXI (T21)**

Request Type: ☐ **Standard** ☐ **STAT*** ☐ **Retro** (service already provided) ☐ **ER or Observation Stay Notification**

**Standard timeframe could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function.*

Member: _____ DOB: _____ Member ID#: _____ Age: _____ Gender: ____

	Requesting Provider	Requested Provider/Facility	PCP (If not already listed)
Provider Name			
Specialty			
Tax ID #			
Contact Name			
Phone #			
Fax #			

Diagnosis Code(s):_____ **CPT/HCPCS Code(s), if applicable:** _____

AUTHORIZATION INFORMATION – Requests require the submission of supporting clinical documentation.

Provider/Facility is: ☐ Participating ☐ Non-Participating (Include address, contact info, NPI #, and for T19 the Medicaid #)

Date of Admit/Service/Appointment: _____ ☐ Elective (Includes scheduled) ☐ Emergent (in 24 hours)

Requested Dates: _____ through _____ **Total:** _____ ☐ Days ☐ Weeks ☐ Months

Procedure: _____

☐ Inpatient Surgery/Services ☐ Outpatient Surgery/Services ☐ Transplantation & Related Care
☐ Experimental/Investigational Treatment ☐ Out-of Network Request for: _____
☐ Other _____

Items/Supplies **

☐ Augmentative Communication System/Device
☐ DME:_____
☐ Orthotics/Prosthetics:_____
Hearing: ☐ Hearing Aids ☐ Cochlear Implant
Nutritional Supplements: (Include forms and order)
☐ Enteral ☐ TPN
Vision: ☐ Contact Lenses ☐ Specialty Glasses

Services/Procedures

☐ Diagnostic Imaging of: _____
☐ MRI ☐ MRA ☐ CT Scan ☐ PET Scan
☐ Genetic Testing***
☐ Oral Surgery (If not performed in an office setting)
☐ Orthodontia ** (Include Medicaid score sheet and films and/or photos if score doesn't meet guidelines)

Days/Week: _____ **Units/Day:** _____ **Total Units:** _____

Choose one service type and include a signed plan of care.

Home Health Services ☐ Home Health Aide
PDN: ☐ LPN ☐ RN ☐ Home Infusion
Therapy ☐ Physical ☐ Occupational
☐ Speech ☐ Respiratory

Applied Behavioral Analysis (ABA) Therapy
Fax to Concordia (305) 514-5321;
Questions : (800) 294-8642

T21 - ☐ Evaluation ☐ Therapy
T19 - *Request through the Local Medicaid Area Office*

Prescribed Pediatric Extended Care (PPEC)

T21 - # Full Days: _____ # Half Days: _____
T19 - *Request through eQHealth @ 1-855-444-3747*

Transportation (For routine, non-emergent transportation to medical appointments)

T21 - *Call LogistiCare @ 1-866-429-8529 to request services* **T19 -** *Call LogistiCare @ 1-866-250-7455 to request services*

**** For services that have a by report (BR) or prior authorization (PA) indicator on the Medicaid Fee Schedule.**
*****If not on Medicaid Fee Schedule, or if genetic testing is with an out-of-network provider.**