PRE-CERTIFICATION/AUTHORIZATION FORM:
For Registered Providers with EPIC Link, please use the web portal to request prior-authorization of medical services.
Phone 1-866-899-4828 | Fax: 1-844-870-0159
Line of Business: ☐**MMA (Medicaid)**

Priority: ☐ **EXPEDITED** (up to 3 business days) When a provider indicates, or the Managed Care plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain or regain maximum function.

☐ **STANDARD (**up to 14 calendar days)

All applicable fields must be completed for faster processing | ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTH

MEMBER'S INFORMATION	
Member's Name:	D.O.B:
Member's Medicaid ID	Phone:
Member's Address:	

REQUESTING PROVIDER INFORMATION (check one)	☐ **PCP**	☐ **Specialist**
Office Contact Name:	Phone:	Fax:
Provider's Name:	Specialty:	
Signature:	Date Form Completed:	

REFERRED TO PROVIDER (check one)	☐ **In-Network**	☐ **Out-of-Network**
Provider/Facility Name:	Phone:	Fax:
Address:	Phone:	Fax:
NPI #:_____ TAX ID:_____		

REQUESTED SERVICES (check one below) **Date(s) of Service:**

☐ Ambulatory Surgery Center ☐ Chemotherapy ☐Dialysis ☐ Durable Medical Equipment
☐ Epidural Pain Management ☐ Home Health Services ☐ Hospital Inpatient ☐ Hospital Observation
☐Hospital Outpatient ☐ Hyperbaric treatment ☐ Obstetrical Global notification ☐ Office
☐ Therapy Services ☐ Transplant related services
(Attach pertinent medical records to assist in medical necessity review)

Diagnosis:	ICD-10:	
Tests/Procedures:	CPT Code(s):	HCPCS:

Therapy Services:☐ PT (97110) ☐ OT (97530) ☐ ST (92507) Visits:_____ Weeks:_____ Total Units_____

Clinical Summary/Findings: Please Attach Pertinent Medical Records to Assist in Authorization

Statement to Provider: This authorization is for Medically Necessary Services Only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits and patient eligibility at the time of service. Additionally, it is important that a report of the treatment provided or service(s) recommended be completed on this member and forwarded to the Primary Care Physician within 7 days of services.