AmeriHealth Caritas North Carolina

Non-Covered State Medicaid Plan Services Prior Authorization Request Form for Recipients Under 21 Years Old

Definitions of federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at: **http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html**

This form **must** accompany your prior approval request for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) consideration via submission through provider portal, fax, or mail. **Do not** send this form to AmeriHealth Caritas North Carolina without an accompanying prior approval request. It will not be processed without a prior approval request.

I. Recipient information: This must be completed by a physician, licensed clinician, or other provider.	
Name:	
Date of birth:	Medicaid ID number:
Address:	

II. Medical necessity: All requested information, including provider information and CPT and HCPCS codes, if applicable, must be completed. Please submit medical records that support medical necessity.			
Requester name:		Provider name:	
NPI:		NPI:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:
Requested procedure, product, or service:			CPT/HCPCS code:
In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)			
What is the recipient's health history? (Include chronic illness.)			
What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)			
What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment[s].)			
Please describe how the requested procedure, product, or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem.) This description must include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.			
Is this request for an experimental or investigational treatment? ☐ Yes ☐ No If yes, provide name and protocol number:			
Is the requested product, service, or procedure considered to be safe? ☐ Yes ☐ No If no, please explain.			
Is the requested product, service or procedure effective? ☐ Yes ☐ No If no, please explain.			
Are there alternatives to the requested product, procedure, or service that would be more cost effective and similarly medically effective? ☐ Yes ☐ No If yes, specify what alternatives are appropriate for the recipient and provide evidence with this request, if available.			
What is the expected duration of treatment?			
Requestor's Signature & Credentials			Date:

Fax this form to **1-833-900-2262**, or call Utilization Management Prior Authorization at **1-833-893-2262**.