AmeriHealth Caritas North Carolina

Prior Authorization Request Form

For prior authorization, fax to **1-833-893-2262**
For inpatient admission notifications and concurrent review, fax to **1-833-894-2262**

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be eligible for NC Medicaid on the date of service or the date the equipment or prosthesis is received by the beneficiary. **See second page for instructions.**

I. General information

1.	2. Name (last, first, M.I.):	3. Date of birth:
4. Address (street, city, state, ZIP code):		
5. NC Medicaid ID number:	6. Diagnosis code:	
7. Diagnosis description:		
8. Name and address of facility where services are to be rendered, if other than home or office:		
9. Inpatient ___ Outpatient ___		

II. Service information

10. Ref. #	11. Procedure code	12. From	13. Through	14. Description of service/item	15. Qty. or units
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

16. Detailed explanation of medical necessity for services, equipment, procedures or prostheses (attach additional pages if necessary):

III. Provider

17. Provider name:

18. Address:

19. NPI:

20. Provider taxonomy:

21. Fax number:

IV. Prescribing or performing provider

22. Name:	23. Phone:
24. Address:	
25. NPI:	
26. Provider taxonomy:	
27. Fax number:	

By submitting this form, the provider identified in this Section IV certifies that the information given in Sections I through III of this form are true, accurate and complete.

Instructions for completion

I. General information (to be completed by the provider requesting the prior authorization)

1. Leave blank.
2. Beneficiary's name — Enter the beneficiary's name as it appears on the NC Medicaid identification card. Enter the beneficiary's current address.
3. Date of birth — Enter the beneficiary's date of birth.
4. Address — Enter the beneficiary's address, city, state, and ZIP code.
5. NC Medicaid number — Enter the beneficiary's NC Medicaid identification number as shown on the NC Medicaid identification card or county letter of eligibility.
6. Diagnosis code — Enter the diagnosis codes.
7. Diagnosis description — Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
8. Name and address of the facility where services are to be rendered, if service is to be provided at a location other than the home or office.
9. Indicate if the request is for inpatient or outpatient services.

II. Service information

10. Ref. # (reference number) — Enter the unique designator (1 – 10) identifying each separate line on the request.
11. Procedure code — Enter the procedure codes for the services being requested.
12. From — Enter the date that services will begin if authorization is approved (MM/DD/YY format).
13. Through — Enter the date services will terminate if authorization is approved (MM/DD/YY format).
14. Description of service/item — Enter a specific description of the service or item being requested.
15. Quantity or units — Enter the quantity or units of the service or item being requested.
16. Detailed explanation of medical necessity of the services, equipment, procedures, or prostheses. Attach additional pages as necessary.

    Do not use another Prior Authorization Request Form.

III. Provider requesting prior authorization

17. Provider name — Enter the requested provider's information. If a clinic or group practice, also complete section IV.
18. Address — Enter the complete mailing address in this field.
19. NPI — Enter the National Provider Identifier.
20. Provider taxonomy code — Enter the provider taxonomy code.
21. Fax number — Enter the requested provider's fax number, including the area code.

IV. Prescribing or performing provider

This section must be completed for services which require a prescription such as durable medical equipment or physical therapy, for services which will be prescribed by a provider that require prior authorization, or when the provider in section IV is a clinic or group practice. Check your provider manual for additional instructions.

22. Name — Enter the name of the prescribing or performing provider.
23. Phone number — Enter the prescribing or performing provider's phone number, including area code.
24. Address — Enter the address, city, state, and ZIP code.
25. NPI — Enter the National Provider Identifier.
26. Provider taxonomy code — Enter the provider taxonomy code.
27. Fax number — Enter the requested provider's fax number, including the area code.

Fax this form to: **1-833-893-2262** or call Utilization Management Prior Authorization: **1-833-900-2262**.
Insert date (MM/DD/YYYY): ____ / ____ / _____