Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THIS FORM.
A COPY OF ALL SUPPORTING INFORMATION IS REQUIRED. LACK OF INFORMATION MAY RESULT IN DELAY OR DISMISSAL OF REQUEST.

Prior authorization request form and required clinical information should be sent to:

or

or

or NH Medicaid Fee-For-Service

Health plan:	☐ Urgent ☐ Standard	Health plan fax:
Service type requiring authorization (check all that apply)		
Ambulatory/outpatient services ☐ Surgery/procedure ☐ Chiropractic ☐ Pain management ☐ DME ☐ Laboratory testing	**Outpatient therapy** (out of home only) ☐ Occupational therapy ☐ Physical therapy ☐ Speech therapy ☐ Pulmonary/cardiac rehab ☐ ABA therapy	**Home health/hospice** ☐ Home health (Please check: ☐ SN ☐ PT ☐ OT ☐ ST ☐ HHA ☐ MSW ☐ Private duty nursing) ☐ Personal care attendant (Please include SCFE form.) ☐ Hospice ☐ Infusion therapy
Pharmacy ☐ Systemic immunomodulators ☐ Hyaluronic acid derivative injections		
Inpatient care/observation ☐ Acute medical/surgical ☐ Obstetrical ☐ Long-term acute care ☐ Acute rehab ☐ Skilled nursing facility ☐ Observation ☐ NICU ☐ Transplant	**Nutrition** ☐ Nutritional counseling ☐ Enteral nutrition ☐ Infant formula ☐ Total parenteral nutrition	**Dental** ☐ Anesthesia ☐ Misc (specify in other below)
☐ **Out-of-network request — please specify service:**		
☐ **Other — please specify service:**		

Member information (*denotes required field)	
*Member ID:	*Date of birth:
*Last name, first name:	

Requesting provider information (*denotes required field)		
*Requesting NPI:	*Requesting TIN:	*Requesting provider:
Contact at requesting provider's office:	*Phone:	*Fax:

Servicing provider/facility information (*denotes required field)		
*Please choose one: ☐ Participating ☐ Non-participating	*Servicing NPI:	*Servicing TIN:
*Servicing Provider:	*Servicing Facility Name:	
*Contact at Servicing Provider's Office:	*Phone:	*Fax:

Authorization request (*denotes required field)	
*Primary procedure code(s):	*Start date or admission date:
Modifiers, if applicable:	*Diagnosis code:
*Additional procedure code(s):	*End date or discharge date:
Modifiers, if applicable:	Total units/visits/days:
For PDN only: ☐ Daytime/evening ☐ Night/weekend ☐ Vent	
Additional comments:	

Please refer to the following payer websites for additional information regarding plan-specific requirements for services that require prior authorization.			
ACNH www.amerihealthcaritasnh.com	NHHF www.nhhealthyfamilies.com	WSHP www.wellsense.org	NH Medicaid FFS www.nhmmis.nh.gov

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

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