RHODE ISLAND MEDICAID PRIOR AUTHORIZATION FORM

Recip MID_____ Last Name_____ First Name_____ Middle_____ Birth Date _____

Ordering, Prescribing, Referring Medicaid Provider Name_____ NPI_____ Taxonomy_____

Performing/Billing Provider Name_____ **Return Mailing Address** _____

City_____ ST_____ ZIP_____ Phone_____ Fax _____

HOSPITALS ONLY **SERVICE TYPE** **INPATIENT** ☐ **OUTPATIENT** ☐ **Under 15 pages FAX 401-784-3892**

The ICD TYP Values are defined as follows: 2=ICD-9, 3=ICD-10

EOHHS ONLY	PERFORMING/ BILLING PROV NPI	TAXONOMY	START DATE	END DATE	PROCEDURE OR REVENUE CODE/MOD	ADD MOD	TTH SRF	ICD TYP	DIAG CODE	UNITS/ OCCUR	DOLLAR AMOUNT

(Reason service is required, diagnosis/prognosis and treatment described) _____

_____

PERFORMING PROVIDER SIGNATURE AND TITLE _____

OFFICIAL USE DO NOT WRITE BELOW

EOHHS AUTHORIZED_____ **EOHHS DENIED**_____ **DATE**_____

NOTES _____

_____

Revised 02-2019