



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**

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 _____

