# Prior Authorization Request

*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 Medicaid Tailored Plan eligible and a Trillium member on the date of service.* ***See reverse side for instructions.***

carolina complete health
Trillium HEALTH RESOURCES

## I. GENERAL INFORMATION

| 1. Name (Last, First, M.I.) | 2. Date of Birth (MM/DD/YY) | 3. NC Medicaid ID Number |
|---|---|---|
| | | |

| 4. Address (Street, City, State, Zip Code) |
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| |

| 5. Diagnosis Code | 6. Diagnosis Description |
|---|---|
| | |

| 7. Name and address of facility where services are to be rendered, if other than home or office |
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| |

## II. SERVICE INFORMATION — FOR PLAN USE ONLY

| 8. REF. NO | 9. Procedure Code | 10. From | 11. Through | 12. Description of Service/Item | 13. QTY or Units | APPR. | Denied | Amount Allowed if Priced by Report |
|---|---|---|---|---|---|---|---|---|
| (1) | | | | | | | | |
| (2) | | | | | | | | |
| (3) | | | | | | | | |
| (4) | | | | | | | | |
| (5) | | | | | | | | |
| (6) | | | | | | | | |
| (7) | | | | | | | | |
| (8) | | | | | | | | |
| (9) | | | | | | | | |
| (10) | | | | | | | | |

| 14. Detailed explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary) |
|---|
| |

## III. PROVIDER

| 15. Provider Name |
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| |

| 16. Address |
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| 17. NPI and TAX ID |
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| |

| 18. Fax Number |
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| |

## IV. PRESCRIBING/PERFORMING PRACTITIONER

| 19. Provider Name | 20. Telephone |
|---|---|
| | |

| 21. Address |
|---|
| |

| 22. NPI and TAX ID |
|---|
| |

**By submitting this form, the Provider identified in this Section V. certifies that the information given in Section I and III of this form is true, accurate, and complete.**

## V. FOR PLAN USE ONLY

| Denial Reason(s): Refer to table above by reference numbers (REF NO.) |
|---|
| |

| **IF APPROVED:** | Services Authorized to Begin | Date | Reviewed by Signature ▶ |
|---|---|---|---|
| | | | |

## Please Fax Completed Form to:

| | | | |
|---|---|---|---|
| Outpatient Medical Requests | **833-875-0930** | Physician Administered Drug Off Label Request | **833-754-0251** |
| Inpatient Medical Face Sheets | **833-875-0650** | Inpatient Medical Concurrent Review | **833-875-2264** |

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# Instructions for Completion

## I. GENERAL INFORMATION - To be completed by the provider requesting the prior authorization.

1. **Beneficiary's Name** - Enter the beneficiary's name as it appears on the NC Medicaid Identification Card. Enter the beneficiary's current address.
2. **Date of Birth** - Enter the beneficiary's date of birth.
3. **Address** - Enter the beneficiary's address, city, state, and zip.
4. **NC Medicaid number** - Enter the beneficiary's NC Medicaid Identification number as shown on the NC Medicaid Identification card or county letter of eligibility.
5. **Diagnosis Code** - Enter the diagnosis code(s).
6. **Diagnosis Description** - Enter the diagnosis description. if there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
7. Name and address of the facility where services are to be rendered, if service is to be provided other than home or office.

## II. SERVICE INFORMATION

8. **Ref. NO.** - (Reference number) a unique designator (1-12) identifying each separate line on the request.
9. **Procedure Code** - Enter the procedure code(s) for the services being requested.
10. **From** - Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
11. **Through** - Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
12. **Description of Service/Item** - Enter a specific description of the service/item being requested.
13. **Quantity or Units** - Enter the quantity or units of service/item being requested.
14. Detailed explanation of medical necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do NOT use another Prior Authorization Form.**

## III. PROVIDER REQUESTING PRIOR AUTHORIZATION

15. **Provider Name** - Enter the requested provider's information. if a clinic or group practice, also complete section v.
16. **Address** - Enter the complete mailing address in this field.
17. **NPI and Tax ID -** Enter the Provider's and taxonomy code (if applicable)
18. **Fax Number** - Enter the requested provider's fax number, including area code.

## IV. PRESCRIBING/PERFORMING PRACTITIONER

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

19. **Name** - Enter the name of the prescribing/performing practitioner.
20. **Telephone Number** - Enter the prescribing/performing practitioner telephone number including area code.
21. **Address** - Enter the address, city, state, and zip code.
22. **NPI and Tax ID -** Enter the Provider's and taxonomy code (if applicable)

## PLEASE FAX COMPLETED FORM TO

| | |
|---|---|
| Outpatient Medical Prior Authorization Requests | **833-875-0930** |
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