



Ohio Medicaid Medical Prior Authorization Supplemental Information Sheet

Please complete all fields on the form for any service requiring authorization. Submitting all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports will help us process your request without delay. Failure to provide sufficient information may delay your request.

A complete list of services requiring prior authorization can be found at https://www.uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home/oh-cp-prior-auth.html

Date: Contact person: Phone: Fax: HIPAA secure fax line? Yes No Requesting Provider: TIN/NPI:

Member Information

Member name: Member ID#: Date of birth:

Type of Request

Inpatient Outpatient Home Care Private Duty Nursing DME Therapy Medications

Servicing Care Provider and Facility Information

Servicing care provider: Address: Date of service: Servicing facility: Address: Facility OH Medicaid ID: TIN/NPI: OH Medicaid ID: Fax: In network Out of network TIN/NPI: In network Out of network

Will out of network care provider accept Medicaid/Medicare default rate? Yes No

Clinical Information

Diagnoses: ICD-10 codes: Required: CPT/HCPCS Code(s): Description required: Miscellaneous and/or unlisted codes: Please provide the requested number of units/mg/mg Number of visits: Start date: End date: Frequency: Durable medical equipment cost: \$ Number of previous visits/service description/CPT/HCPCS codes: Clinical information:

\*Please attach relevant clinical data such as progress notes, evaluations, treatment rendered, tests, lab results, md order/prescriptions, and/or radiology reports when you submit your request.

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