

8.1 Prior Authorization Request Form

<p>Prior Authorization Request Form – General Instructions</p> <ul style="list-style-type: none"> Submit all requests 2 weeks prior to scheduled date of service. Incomplete forms will be returned and may delay the authorization process. Documentation related to the service(s) requested should be sent with the request. FAX or mail completed forms to the FAX number/address at right. <p>For both Diamond State Partners (DSP) and Delaware Medicaid & Medical Assistance (DMMA) programs, review the Delaware Medical Assistance Program manuals for instructions and form downloads at http://www.dmap.state.de.us/downloads/manuals.html.</p> <p>For questions, contact Provider Relations at 302-454-7154 / 800-999-3371.</p>	<p>Fax To: 1-302-255-4481</p> <p>Department of Health & Social Services Diamond State Partners and / or Division of Medicaid & Medical Assistance 1901 N. Dupont Hwy, Lewis Building P.O. Box 906 New Castle, DE 19720</p> <hr/> <p>Date Received: _____</p> <p style="text-align: center;"><input type="checkbox"/> DSP or <input type="checkbox"/> FFS</p> <p>Eligibility Effective Date: _____</p>
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A. MEMBER INFORMATION

Name:	Medicaid ID:	D.O.B.:
Address:		Phone:
<i>Other Health Insurance (OHI) Information</i>		
Name:	Policy #:	
Policyholder Name:	Policyholder SSN:	

B. ORDERING PROVIDER INFORMATION

Name:	FAX Number:
Address:	
Person Completing Form:	Telephone Number:
NPI (National Provider ID) + Taxonomy:	

C. PRIMARY PHYSICIAN INFORMATION

Name:	Telephone Number:
NPI (National Provider ID) + Taxonomy:	

D. DME / HHC INFORMATION

Name:	Telephone Number:
NPI (National Provider ID) + Taxonomy:	

E. SERVICE INFORMATION

Service Dates: FROM:	TO:	Continuation of Service <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis(es) / Service(s) / Procedure(s)		
Diagnosis(es) / ICD-9:		
CPT / HCPCS Codes:		

F. PLACE OF SERVICE: Out of State Provider: Yes No

Name:	Telephone Number:
NPI (National Provider ID) + Taxonomy:	

CHECK SERVICES REQUESTED

<input type="checkbox"/> Durable Medical Equipment (DME)	<input type="checkbox"/> Surgery / Diagnostic Testing / Other
<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> Home Health Care (HHC) Service(s) – Please specify
	<input type="checkbox"/> Skilled Nursing Visits <input type="checkbox"/> Home Health Aid (if greater than two hours per day)
	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy
	<input type="checkbox"/> Speech Therapy

DO NOT WRITE BELOW THIS LINE

Date Reviewed:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Incomplete	Authorization #:
Signature:	Comments:	