Maryland
DEPARTMENT OF HEALTH

This form must be completed and submitted by the ordering providers office. Maryland Medicaid will not reimburse testing that was performed prior to receiving authorization approval. Please note the following:

It is the provider's responsibility to check EVS prior to rendering services to ensure participant's eligibility for a specific date of service.

Step 1: Verify the participant's eligibility by either:

- Calling the Medicaid EVS hotline at 1-866-710-1447 and following the instructions; or
- Logging into the Web-EVS system through eMedicaid at http://emdhealthchoice.org. Providers must be enrolled in eMedicaid to utilize this option.

Note: To enroll in eMedicaid, go to the URL above and select Services for Medical Care Providers and follow the login instructions. If you need information, please visit the website or, for provider application support, call 410-767-5340.

Step 2: Determine whether the participant has coverage through both Medicaid AND Medicare.

- If yes, do not continue with the preauthorization process. Submit the claim to Medicare for processing.
- If no, proceed to the next step.

Step 3: Determine whether the participant has coverage through the Medicaid HealthChoice program.

- If yes, call the participant's HealthChoice MCO to obtain the needed preauthorization; or
- If No, proceed to the next step.

Step 4: Access the Provider information on the Maryland Health Department webpage https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx, scroll down to the **Dental and Laboratory Information** section and select the most recent Laboratory Services Fee Schedule. Locate the CPT procedure codes the participant is planning to receive. In the **"PA Required"** column next to your code, determine whether it is blank or if it has the letter "P".

- If blank, then the procedure does not require preauthorization through Maryland Medicaid; or
- If an indicator "P" is present, then a preauthorization is required. Click on the P to access the review process for the CPT code selected.
- If preauthorization is required, go to the Preauthorization Information page to access the Preauthorization Request Form for Laboratory Services. Once completed, fax it to:

Preauthorization Review Unit

Acute Care Administration

(410) 767-6034

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PREAUTHORIZATION REQUEST FORM

LABORATORY SERVICES

Participant Information

Name:	Date of Birth:
Medicaid Number:	Sex:

Ordering Provider Information

Name:		MA Provider Number:
Street Address:		Telephone:
City, State, Zip:		Fax:
Contact information for person completing this form:		
Name:	Email:	Phone:

Genetic Counselor Information – **FOR GENETIC TESTING REQUESTS**

Name:		MA Provider Number:
Street Address:		Telephone:
City, State, Zip:		Fax:
Contact information for person completing this form:		
Name:	Email:	Phone:

Testing Laboratory Information

Name:		MA Provider Number:
Street Adress:		Telephone:
City, State, Zip:		Fax:
Laboratory Contact Person:		
Name:	Email:	Phone:

PREAUTHORIZATION REQUEST FORM

LABORATORY SERVICES

Preauthorization Information

Requested Test Name:	CPT/HCPCS code(s):
Diagnosis:	ICD-10 code(s):

Preauthorization Line Item Information

CPT code	Mod 1	Mod 2	Requested Units	Department Use Only

Required Clinical Information for all Laboratory Requests:

Please attach documentation which includes but is not limited to the following:

- Complete narrative justification for procedure(s)
- Clinical note (including history and physical examination) from ordering provider
- Result of pertinent ancillary studies if applicable
- Pertinent medical evaluations and consultations if applicable

For Genetic Testing, please provide the following information:

Describe the laboratory and/or clinical testing that has been performed to date:

Describe why genetic testing is necessary at this time:

Describe how the results of the genetic test, whether negative or positive, will impact the future management of the participant being tested. Specifically, it will: (check all that apply)

☐ Inform on prognosis:
Explain:

☐ Change treatment plan (ie, medical or surgical decision-making or treatment):
Explain:

☐ Change surveillance (e.g., begin or stop annual echocardiograms)
Explain:

☐ Prevent the need for further diagnostic testing:
Explain:

☐ Provide information for family members:
Explain:

What is the probability that this test will be positive?
If this is not known, then please indicate which clinical features increase the probability that this test will provide a diagnosis.

If this is a request for a gene panel, please describe why a single gene test is not as useful:

If the genetic test is for an inherited condition, please describe how the participant is at risk of inheriting the genetic mutation and attach a three-generation pedigree:

Preauthorization Number (Department Use Only)

Submission Instructions:
Fax completed form and all requested attachments to:
1-410-767-6034