MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
PHYSICIAN SERVICES

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|

Name ____________________ (Last) (First) (MI) DOB __________ Sex ___ Telephone (___)__________

Address ____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_| Request Date __________

Name ____

Address ______________________________ Telephone (___) __________

Contact ____

Provider's Signature ____

SECTION III - Additional Preauthorization Information

Referring Provider |_|_|_|_|_|_|_|_|

Name ______________________________

Address ______________________________

Rendering Provider |_|_|_|_|_|_|_|_|_|

Name ______________________________

Address ______________________________

Telephone (___) __________

Dates of Service: From: ________ Thru: ________

Diagnosis Codes: 1_____ 2_____ 3_____ 4_____

SECTION IV - Preauthorization Line Item Information

CODE	MOD1	MOD2	REQUESTED UNITS	DEPARTMENT USE ONLY
____	____	____	______	
____	____	____	______	
____	____	____	______	
____	____	____	______	

SECTION V - Specific Program Preauthorization Information

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

A. Complete Narrative Justification for procedure(s)
B. Brief history and physical examination
C. Result of pertinent ancillary studies if applicable
D. Pertinent medical evaluations and consultations if applicable

PREAUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

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