Maryland
DEPARTMENT OF HEALTH

PREAUTHORIZATION REQUEST FORM
PHYSICIAN SERVICES

SECTION I- PATIENT INFORMATION

MEDICAID NUMBER (11 DIGIT)		TELEPHONE
NAME (LAST, FIRST, MI)		ADDRESS
DOB	SEX	

SECTION II- PROVIDER INFORMATION

PAY TO PROVIDER # (9 DIGIT)	**RENDERING** PROVIDER # (9 DIGIT)
NAME	NAME
ADDRESS	ADDRESS
TELEPHONE	TELEPHONE
PROVIDER SIGNATURE	
Contact information for person completing this form:	

NAME	EMAIL	PHONE

SECTION III- PREAUTHORIZATION INFORMATION

REQUEST DATE	DATES OF SERVICES: FROM THRU
DIAGNOSIS CODES: 1.	2. 3.

SECTION IV- PREAUTHORIZATION LINE ITEM INFORMATION

CODE	MOD 1	MOD 2	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 (DEPARTMENT USE ONLY)

SUBMISSION INSTRUCTIONS:
Fax completed form and all required attachments to:
1-410-767-6034.