Outpatient Prior Authorization Form

This form may be filled out by typing in the field, or printing and writing in the fields. Please fax completed form to CHNCT at 1.203.265.3994. Please call CHNCT's provider line at 1.800.440.5071 with any questions.

BILLING PROVIDER INFORMATION	MEMBER INFORMATION
1. Medicaid Billing Number:	7. Member ID Number:
2. Billing Provider Name:	8. Member Name (Last, First):
3. Street Address:	9. Street Address:
4. City, State, Zip:	10. City, State, Zip:
5a. Contact Name/Telephone Number:	11. Date of Birth (MM/DD/YYYY):
	12. Sex:
5b. Contact Fax Number:	13. Primary Diagnosis Code:
6. Referring MD/Information: Name, Address, Medicaid ID #, Phone #, and Fax #	14. Estimated Delivery Date (DME ONLY) (MM/DD/YYYY):

15. Authorization Service Requested (Check all that apply):				
☐ Customized Wheelchair	☐ Medical/Surgical Services	Independent Chiropractic	☐ Evaluation	☐ Initial ☐ Re-Auth
☐ DME	☐ Orthotic & Prosthetic Devices	Home Health		☐ Initial ☐ Re-Auth
☐ Genetic Testing/Lab Services	☐ Oxygen	Occupational Therapy		☐ Initial ☐ Re-Auth
☐ Hearing Aids	☐ Professional/Surgical Services	Physical Therapy		☐ Initial ☐ Re-Auth
☐ Hospice	☐ Vision Care Services	Speech Therapy		☐ Initial ☐ Re-Auth

16a. HUSKY Plus: ◯ Yes ◯ No	16b. Birth to Three Provider: ◯ Yes ◯ No

17. Dates of Service			18. Place of Service	19. Proc/RCC Code/List	20. Mod 1	21. Mod 2	22. Mod 3	23. Units	24.Total Cost Dollars
Line Item	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)							
1									
2									
3									
4									
5									
6									
7									
8									

25. Clinical Statement: Include a prognosis and rehabilitation potential in the space provided below. A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of service requested must be attached.
Signature of Clinical Practitioner: Date:

26. Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may be subject me to civil and criminal liability.

Signature of Billing Provider:_____ Date: _____

PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS		
#	**Field Name**	**Description**
1	Medicaid Billing Number	Enter the provider's NPI number or the CMAP identification number (AVRS #) that has been issued to the provider upon enrollment in the Medicaid Program, if the provider is unable to obtain an NPI.
2	Billing Provider Name	Enter the billing provider's name.
3	Street Address	Enter the billing provider's street address.
4	City, State Zip	Enter the billing provider's city, state, and zip code.
5a	Contact Name/ Telephone Number	Enter the billing provider's contact name and telephone with area code.
5b	Contact Fax Number	Enter the billing provider's fax number with area code.
6	Referring MD Information: Name, Address, Medicaid ID #, Phone #, and Fax #	Enter the full name, address, CMAP identification number (AVRS #), phone number, and fax number of the Referring MD
7	Member ID Number	Enter the member identification number as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS).
8	Member Last Name	Enter the member's name as it appears on the member's CONNECT Card or from AEVS.
9	Street Address	Enter the member's address. If the member resides at a facility or institution, document that information in this field.
10	City, State Zip	Enter the member's city, state, and zip code. If the member resides at a facility or institution, enter that facility or institution's city, state, and zip code.
11	Date of Birth	Enter the member's date of birth in the MM/DD/YYYY format.
12	Sex	Enter the member's gender.
13	Primary Diagnosis Code	Enter the member's primary diagnosis code.
14	Estimated Delivery Date	Enter the estimated date of DME delivery in the MM/DD/YYYY format.
15	Authorization Service Requested	Select the appropriate prior authorization type being requesting (check all that apply). For outpatient therapy requests (occupational, physical and speech), be sure to indicate whether requested services are for initial or re-authorization. For independent chiropractic service requests please be sure to indicate whether requested services are for evaluation, initial or re-authorization.
16a	HUSKY Plus	Indicate when a HUSKY B member needs supplemental services beyond those available under HUSKY B. HUSKY Plus covers: long-term rehab, DME, prosthetics & orthotics, medical/surgical supplies, and hearing aids.
16b	Birth to Three	Enter if you are a Birth to Three provider.
17	Dates of Service	Enter the requested start and end dates for the requested services in the MM/DD/YYYY format.
18	Place of Service	Enter the place of service where the procedure or service will be provided; no code is needed just a description of the place of service.
19	Proc/RCC Code/List	Enter the code/list for the procedure/revenue center code (RCC) for the service.
	Note for Home Health Providers, Independent Therapists, Physician Therapy Groups and Rehab Clinics	Please refer to following link for codes and instructions: Outpatient Authorization Request Form Instructions (If you are on a PC, "ctrl + click" the link to download the instructions. If you are on a Mac, single click the link.)
20-22	Mod 1, Mod 2, Mod 3	Enter first, second, and third modifier code(s) for the procedure required, if applicable.
23	Units	Enter the number of units requested.
24	Total Cost Dollars	Enter the total amount, in dollars, for the units of service requested if applicable.
25	Clinical Statement/ Signature of Clinical Practitioner	The Clinical Practitioner should enter a comprehensive statement indicating the clinical necessity, the plan of treatment, and the desired outcome for the services requested. The Clinical Practitioner should sign and date the PA Request Form. Signature stamps are unacceptable. For initial home health and therapy requests, this signature is optional. For general inpatient hospice requests beyond 5 days, explain why pain control or acute or chronic symptom management cannot be managed in other settings. For Medicaid members only: For hospice services that exceed a period of 12 months, explain why the continuation of the hospice benefit is clinically indicated for this patient given that hospice services are generally indicated for clients with a life expectancy of 6 months or less.
26	Certification Statement/ Signature of Billing Provider	Enter the full name signature for the billing provider and corresponding date. Signature stamps are unacceptable. A request form without original signature will be rejected.