NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

273 AT FFS
07/2023

REQUEST FOR
SERVICE AUTHORIZATION
FOR SERVICES NOT
ADDRESSED ON OTHER FORMS
(Fee-for-Service (FFS) Program Only – Not for Managed Care program use)

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS CODES: _____

ALTERNATE INSURANCE PLAN NAME: _____
Providers are expected to follow all third party payors requirements for payment and all third party obligations shall be exhausted before billing Medicaid, in accordance with 42 CFR 433.139.

PROVIDER INFORMATION

CONTACT PERSON:_____ EMAIL: _____

TELEPHONE #: _____Ext:_____ FAX #:_____

PERFORMING PROVIDER: _____ PROVIDER MEDICAID ID #: _____

REQUESTING FACILITY:_____ REQUESTING FACILITY MEDICAID ID #:_____

ORDER INFORMATION

DESCRIPTION	CPT Code	Number of units	Start of Service	End of Service	State use only

*** must be included with submission ***
CLINICAL INFORMATION Pursuant to He-W 520.02(b)(2) Request and obtain prior authorization from the department before providing any Medicaid covered services requiring prior authorization.
A Doctor's order, letter of medical necessity and clinical information supporting the medical necessity for the request, including, but not limited to, the medical care plan, relevant diagnostic tests, and progress notes must be attached.

I certify that I have attached a Physician's order and a LMN pursuant to He-W 571.05(d). I certify that products/procedure listed will be provided to the recipient.

_____
Signature *Date*

_____
Printed Name *Title*

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

PLEASE FORWARD THIS INFORMATION TO ATTENTION – MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 314-8101