272X FFS
07/2023

NEW HAMPSHIRE MEDICAID

REQUEST FOR SERVICE AUTHORIZATION
FOR DIAGNOSTIC IMAGING

(Fee-for-Service (FFS) Program Only –
Not for Managed Care program use)

For State use only. Administrative **APPROVAL** per Medical Director

Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

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 FACILITY: _____ **PERFORMING MEDICAID ID#:**_____

PERFORMING FACILITY FAX #: _____

Requested Procedure	CPT Code and Modifier	Date of Service Begin Date	End Date	State Use Only

PHYSICIAN'S ORDER AND LETTER OF MEDICAL NECESSITY

Pursuant to He-W 569.06© Request for Prior Authorization for Diagnostic Imaging, 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.

******* must be included with submission *******

I certify that I have obtained and attached a Physician's order and a LMN pursuant to He-W 569.06 (c). I have attached medical records to support the medical necessity of this diagnostic imaging.

_____

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