NEW HAMPSHIRE MEDICAID

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

Dates of Service: _____

EPSDT: _____SA #: _____

273S FFS
07/2023

REQUEST FOR SERVICE AUTHORIZATION
FOR SURGICAL PROCEDURES, INCLUDING ORGAN TRANSPLANTS
Fee-for-Service (FFS) Program Only –
Not for Managed Care program use
PLEASE PRINT OR TYPE ALL INFORMATION (All fields are required)

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RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH:_____
RECIPIENT MEDICAID ID #: _____DIAGNOSIS (NOT CODES): _____
ALTERNATE INSURANCE: _____

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: _____ CONTACT EMAIL: _____
CONTACT PHONE #:_____EXT:___ CONTACT PERSON FAX #: _____
ADMITTING FACILITY NAME: _____ ADMITTING FACILITY MEDICAID ID #: _____
PERFORMING PHYSICIAN: _____ PERFORMING PHYSICIAN MEDICAID ID #: _____
ADMISSION DATE:_____DISCHARGE DATE: _____

SURGICAL PROCEDURE OR TYPE OF ORGAN TRANSPLANT FOR WHICH SERVICE AUTHORIZATION IS BEING REQUESTED

Procedure	Procedure Code and Modifier	CORRESPONDING ICD-CM CODE	Anticipated Dates of Service	
			Begin Date of Service	End Date of Service

Pursuant to He-W 531.07(d) Prior authorization requested in accordance with 531.07(a) through (c) shall be approved by the department's prior authorization agent if the department's prior authorization agent determines that the submitted documentation supports the applicable requirements in He-W 531.05.

*** must be included with submission ***
Attached are the physician order and a medical record to support the request.
To the best of my knowledge, the above information is true and accurate and supports medically necessary criteria as specified in the Physician Services rule (He-W 531) for the surgical procedure/organ transplant identified above.

Signature of Performing Physician 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 ■FAX: (603) 314-8101