NEW HAMPSHIRE MEDICAID

272EPOS FFS
07/2023

REQUEST FOR SERVICE AUTHORIZATION

IN EXCESS OF SERVICE LIMITS NOT THERAPY, NOT INCONTINENCE

For State use only. **APPROVED**
Date: _____________ By: _______________
Dates of Service: _________________________
EPSDT: _____SA #: ______________________

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

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****
Must use a separate request form for each discipline

RECIPIENT INFORMATION

RECIPIENT NAME: ___________________________________DATE OF BIRTH: _________________

RECIPIENT MEDICAID ID #: __________________________DIAGNOSIS (**NOT CODES**): _________________________

ALTERNATE INSURANCE: NAME OF PLAN:

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 #:________________

TYPE OF TREATMENT	PROC-EDURE CODE	NUMBER OF VISITS PER WEEK IF APPLICABLE	NUMBER OF HOURS PER VISIT IF APPLICABLE	DATES OF SERVICE		STATE USE ONLY
				START DATE OF SERVICE	END DATE OF SERVICE	

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*****CLINICAL INFORMATION** (must be included with submission):***

Pursuant to He-W 568.06: Please attach physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Doctor's order, LMN, and medical records.

LETTER OF MEDICAL NECESSITY

Pursuant to He-W 530.07(g) attach supporting clinical documentation that addresses how the requested additional services meet the definition of medical necessity.

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

Signature of Provider ***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