

PRIOR AUTHORIZATION

Type or Print Legibly

State Use Only

Prior Authorization Control Number

Check type of Medical Card: Medicaid Disability Assistance (DA) QMB Healthcheck Other _____

The Provider is responsible for verifying client eligibility at the date of service by viewing the client's Medical card.

Provider Information

Provider Number (7 digit number)	NPI
Provider Name	
Street Address	
City, State and Zip Code	
Provider Telephone Number and Ext.	Provider Fax Number
Contact Person	Date Form Completed

Client Information

Case Number (12 digit number)		
Last Name	First Name	
Street Address/Facility Name and Address		
City and Zip Code	County	
Client Resides: <input type="checkbox"/> LTC Facility <input type="checkbox"/> MRDD Facility		Date of Birth
<input type="checkbox"/> Personal Residence		
<input type="checkbox"/> Other, specify _____		

Attach Prescription/Certification signed by the appropriate physician or practitioner including the complete diagnosis medical history, degree of impairment, and medical necessity. Give complete description of service or item (including make, model, serial number, freight charges and NDC code.) Attach any additional supportive information.

SERVICE/RENTAL DATES

No Previous Service

Previous Service/Rental Dates (inclusive)
 FROM:
 TO:
 PA#:
 Bill Direct Dates:

This Request – Service/Rental Dates
 FROM:
 TO:

Dispense Date

REQUESTED SERVICES

	Quantity				Procedure Code								Usual and Customary Charge					
1.																		
2.																		
3.																		
4.																		
5.																		
6.																		

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

Notes:

STATE USE ONLY – DO NOT COMPLETE SECTIONS BELOW

Line No.	Quantity	Procedure Code	Approved Dollar Amount	Approve	Deny	Reason Code	Override Code	Reviewer
1.								
2.								
3.								
4.								
5.								
6.								

Submit to Ohio Department of Job and Family Service, Prior Authorization P.O. Box 1002, Columbus, Ohio 43216-0002. Do not send claim with this form. Approved prior authorization is **contingent upon eligibility** of provider and consumer at the time of service and the department's claim and prior authorization filing limitations. Completion of this form is required by rule 5101:3-1-31 of the Ohio Administrative Code for provider to be eligible for reimbursement of Medicaid Services requiring prior authorization.