New Mexico Medicaid Managed Care
Prior Authorization Request Form

Request Date: _____

☐ **BCBS** ☐ **Molina** ☐ **Presbyterian** ☐ **United Healthcare**

☐ **Routine**
☐ **Urgent or Expedited Initial Determination**
For a Prior Authorization request to be considered "Urgent" or "Expedited," the request must include a provider's order stating that waiting for a decision under a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain. Provider's signature below is an attestation that this request meets expedited/urgent criteria listed here.

Practitioner Signature:_____(Required for Urgent or Expedited requests)

Member Information: Complete the information below and attach all of the clinical information pertinent to the request.

Member Name:	ID Number:	DOB:
Other Carrier:	Policy/ID #:	Phone No.

Provider Information

Requesting Provider:	Phone:	Fax:
Servicing Provider/Facility:	Phone:	Fax:
Servicing Provider/Facility Address:		
Tax ID/NPI #:		

☐ New/Initial Request ☐ Ongoing Care Previous Authorization Number: _____
☐ DME/Prosthetic/Orthotic ☐ Ambulatory/Outpatient Surgery ☐ Office ☐ Home Birth
☐ Out-of-Plan Services ☐ Inpatient LOS:_____Facility: _____
☐ PT/OT/ST ☐ Practitioner's Order Attached ☐ Clinical Information Attached ☐ Other: _____

Diagnosis(es) (ICD-9) (Required): _____ _____ _____ _____ _____

Procedure (Must match CPT code/s):_____

Procedure(s) (CPT/HCPC) (Required): _____ _____ _____ _____ _____

Requested Effective Date:_____ **End Date:**_____ **Number of Visits/Units:** _____

Please attach all supporting clinical information to include symptoms, past medical history, diagnostic testing, conservative treatment prior to request.

Services requested. Submit all relevant clinical data to support the request for services. Failure to provide supporting documentation will delay processing and may result in a denial.

For Health Plan Use ONLY: (this would be to communicate authorization information)