

# CCP Prior Authorization Request Form

*If any portion of this form is incomplete, it will be returned.*

**Fax completed forms to 1-512-514-4212**

|  |   |                                   |   |   |                                |
|--|---|-----------------------------------|---|---|--------------------------------|
| <b>Request for:</b>  | <input type="checkbox"/> DME            | <input type="checkbox"/> Supplies | <input type="checkbox"/> Private Duty Nursing | <input type="checkbox"/> Inpatient Rehabilitation | <input type="checkbox"/> Other |
| <b>Section A: Client Information</b>   |   |                                   |   |   |                                |
| Client Name (Last, First, MI):   |   |                                   |   |   |                                |
| Medicaid Number (PCN):   |   |                                   | Date of Birth: / /                            |   |                                |
| <b>Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information</b>  |   |                                   |   |   |                                |
| Supplier Name:   |   | Telephone:                        |   | Fax Number:                                       |                                |
| Supplier Address:  |   |                                   |   |   |                                |
| TPI:   |   | NPI:                              |   | Benefit Code:                                     |                                |
| QRP Name:  |   | QRP TPI:                          |   | QRP NPI:  |                                |
| <b>Section C: Diagnosis and Medical Necessity of Requested Services</b>  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
| <b>Section D: Dates of Service and HCPCS Code</b>  |   |                                   |   |   |                                |
| Dates of Service   |   | From: / /                         |   | To: / /   |                                |
| HCPCS Code/Modifier  | Brief Description of Requested Services | Quantity/Frequency                | Retail Price                                  |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
|  |   |                                   |   |   |                                |
| <i>Note: HCPCS codes and descriptions must be provided.</i>  |   |                                   |   |   |                                |
| <b>Section E: Primary Practitioner's Certifications</b> —To be completed by the primary practitioner   |   |                                   |   |   |                                |
| <b>By prescribing the identified DME and/or medical supplies, I certify:</b>   |   |                                   |   |   |                                |
| <ul style="list-style-type: none"> <li>• The client is under 21 years of age AND</li> <li>• The prescribed items are appropriate and can safely be used by the client when used as prescribed</li> </ul>                                       |   |                                   |   |   |                                |
| <b>By prescribing Private Duty Nursing, I certify:</b>   |   |                                   |   |   |                                |
| <ul style="list-style-type: none"> <li>• The client is under 21 years of age AND</li> <li>• The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.</li> </ul> |   |                                   |   |   |                                |
| Signature of prescribing physician:  |   |                                   |   | Date:   |                                |
| Printed or typed name of physician:  |   |                                   |   |   |                                |
| TPI:   |   | NPI:                              |   | License Number:                                   |                                |