



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION IN EXCESS OF SERVICE LIMITS

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ **RECIPIENT MEDICAID ID:** _____

PROVIDER INFORMATION

DATE OF REQUEST: ___/___/_____ **CONTACT PERSON #:** _____

PROVIDER NAME: _____ **NH MEDICAID PROVIDER #:** _____

ADDRESS: _____ **CITY/STATE/ZIP:** _____

TELEPHONE #: _____ **FAX #:** _____

DIAGNOSIS (written & ICD9) PRIMARY: _____

SECONDARY: _____

Type of Treatment	Procedure Code	Freq of Treatment	Total # of Units	Dates of Service	
				Start	End

ANTICIPATED RESULT(S) OF PROVIDING THESE EXTRA SERVICES:

CLINICAL INFORMATION:

Please attach physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

**CERTIFICATION OF MEDICAL NECESSITY
(to be signed by a PCP or treating physician / ARNP)**

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 _____ **Date**

Please print:

Name/Title _____ **Specialty**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

8 Commerce Drive ■ 2nd Floor ■ Bedford, NH 03110 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335