



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION

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

RECIPIENT NAME: _____ RECIPIENT MEDICAID ID: _____

D.O.B.: _____

PROVIDER INFORMATION

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

ORDERING PHYSICIAN: _____ NH MEDICAID PROVIDER #: _____

TELEPHONE #: _____ FAX #: _____

FACILITY NAME (IF APPLICABLE): _____

SERVICE(S) REQUESTED: _____

DATE OF SERVICE / DATE RANGE: ___/___/_____ TO ___/___/_____

PLEASE PROVIDE THE FOLLOWING AS NECESSARY

ICD-9 CODE(S): _____ CPT CODE(S): _____

HCPCS CODE(S): _____ REV CODE(S): _____

CLINICAL INFORMATION:

Please attach physician's order and clinical notes supporting the medical necessity for the requested services.

THIS REQUEST FOR PRIOR AUTHORIZATION FORM MUST BE COMPLETED WITH ALL REQUIRED INFORMATION TO ENSURE TIMELY PROCESSING

For Internal use only:

Authorization Number: _____

Authorization completed by: _____
(Name)

Date of completion: _____

Criteria Utilized: _____

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