RHODE ISLAND MEDICAID PRIOR AUTHORIZATION FORM

Recip MID _____Last Name _____First Name _____ Middle ____ Birth Date _____

Ordering, Prescribing, Referring Medicaid Provider Name _____NPI _____Taxonomy _____

Performing/Billing Provider Name_____ **Return Mailing Address** _____

City _____ ST _____ ZIP _____ Phone _____ Fax _____

HOSPITALS ONLY **SERVICE TYPE** **INPATIENT** ☐ **OUTPATIENT** ☐

The ICD TYP Values are defined as follows: 2=ICD-9, 3=ICD-10

EOHHS ONLY	BILLING PROV NPI	TAXONOMY	START DATE	END DATE	PROCEDURE OR REVENUE CODE/MOD	ADD MOD	TTH SRF	ICD TYP	DIAG CODE	UNITS/ OCCUR	DOLLAR AMOUNT

(Reason service is required, diagnosis/prognosis and treatment described) _____

_____

PERFORMING PROVIDER SIGNATURE AND TITLE _____

OFFICIAL USE DO NOT WRITE BELOW

EOHHS AUTHORIZED _____**EOHHS DENIED** _____ **DATE** _____

NOTES _____

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