



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**

Under 15 pages FAX 401-784-3892

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

EOHHS ONLY	PERFORMING/ 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 _____ DATE _____

OFFICIAL USE DO NOT WRITE BELOW

EOHHS/Designee Authorized _____ EOHHS/Designee Denied _____ DATE _____

NOTES _____
