RHODE ISLAND MEDICAID
COMMUNITY HEALTH WORKER PRIOR AUTHORIZATION FORM

Recip MID_____Last Name_____First Name_____Middle_____Birth Date_____

LPHA Provider Name_____NPI_____Taxonomy_____

LPHA Mailing Address_____City_____ST_____ZIP_____

LPHA Phone_____ LPHA Fax_____ CHW Provider Referred to: _____

Submit completed form to Gainwell via Fax, Encrypted Email or Postal Mail.

Fax: 401 784 3892 Encrypted Email: rixix-pa@gainwelltechnologies.com Mail: Gainwell P.O. Box 2010, Warwick, RI 02887-2010

*CHW PRIOR AUTH. FORM IS TO BE **FILLED AND SIGNED BY LPHA** REFERRING THE SERVICES. AUTHORIZATION IS FOR A **MONTH** SPAN ONLY

EOHHS ONLY	CHW PROVIDER NPI	TAXONOMY	START DATE	END DATE	PROCEDURE CODE	ADD MOD	PLACE OF SERVICE	DIAG CODES	UNITS

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

_____

REFERRING LPHA SIGNATURE AND TITLE_____**DATE**_____

OFFICIAL USE DO NOT WRITE BELOW

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

NOTES _____

_____

Revised 07/2025