

Prior Authorization Data Correction Form

Purpose: Use this form to correct or modify non-clinical, administrative data on a previously submitted prior authorization request. This form cannot be used to request re-determination of medical necessity, nor does it take the place of a prior authorization request. Please allow up to 30 days for processing.

Attachments: Attachments are not required with this form. Documentation to fully support medical necessity must be submitted with the prior authorization request and be available in the recipient's medical record.

Fax this form to: (866) 480-9903

Questions: If you have any questions, please call HP Enterprise Services at (800) 525-2395.

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| Submission Date of This Form: | Date(s) of Service: |
| Are you an out of state provider? <input type="checkbox"/> No <input type="checkbox"/> Yes | Does TPL exist? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| SERVICE TYPE <i>Indicate the type of service for which you are requesting a data correction.</i> | |
| <input type="checkbox"/> ADHC <input type="checkbox"/> Behavioral Health <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Inpatient Medical/Surgical <input type="checkbox"/> Inpatient LTAC <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Outpatient Medical/Surgical <input type="checkbox"/> Outpatient Rehab <input type="checkbox"/> Outpatient Therapy <input type="checkbox"/> RTC | |
| AUTHORIZATION NUMBER | |
| 11-digit Authorization Number assigned to your original request: | |
| BILLING PROVIDER INFORMATION | |
| Provider Name: | NPI: |
| Contact Name: | |
| Phone: | Fax: |
| INFORMATION TO MODIFY | |
| What non-clinical data on your original request should be modified? | |
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| | |
| Why should this data be modified? | |
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| RECIPIENT INFORMATION | |
| Recipient Name: | |
| Date of Birth: | Recipient ID: |
| Admission Date or Begin Date of Service: | Discharge Date: |
| HP ENTERPRISE SERVICES USE ONLY | |
| Name: | |
| Comments: | |
| | |
| Signature: | |