Prior Authorization Request
HP Enterprise Services - Nevada Medicaid and Nevada Check Up

Outpatient Medical/Surgical

(Use Form FA-7 for Outpatient Rehabilitation and Therapy Services)

Fax this request to: (866) 480-9903

For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: ______ /______ /________

REQUEST TYPE: ☐Initial ☐Continued Services ☐Retrospective* ☐Unscheduled Revision

*REQUIRED FOR RETROSPECTIVE REVIEWS ONLY
This recipient was determined eligible for Medicaid benefits on: ______ /______ /________

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Address:		Phone:
City:	State:	Zip Code:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	
Responsible Party Name (if applicable):		
Responsible Party Address:		Phone:

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name:		

SERVICING PROVIDER INFORMATION

Servicing Provider Name:		
NPI:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name:		

CLINICAL INFORMATION *(attach additional sheets if necessary)*

Code Requested	No. of Units Requested	Description of Service	HP ENTERPRISE SERVICES USE ONLY		
			Units Approved	Status	Action Code
1.					
2.					
3.					
4.					
5.					

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Is the service you are requesting a hospice benefit? ☐ Yes ☐ No

Are you requesting Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No

Conditions/Symptoms (include ICD-9 codes and descriptions):

Previous Treatment/Services *(include dates)*:

Results of Previous Treatment/Services:

Other Clinical Information *(to support medical necessity of the requested services)*:

HP ENTERPRISE SERVICES USE ONLY

Approved From:	Approved Through:
Denied From:	Denied Through:
Reviewer Signature:	Date:

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