## STATE OF COLORADO **DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

INVOICE//PAT. ACCOUNT NUMBER

## **MEDICAID PRIOR AUTHORIZATION REQUEST**

(PAR) To avoid delay, please answer all questions completely.									DOES CLIENT HAVE PRIMARY INSURANCE? YES NO	
1. CLIENT NAME (Last, First, Middle Initial)					CLIENT IDENTIFICATION N	UMBER	3. SEX	4. DATE OF BIRTH	(MMDDYY)	
							□м	<b>□</b>		
5. CLIENT	ADDRESS (Street, City, State, ZIP Co	de)						6. CLIENT TELEPH	HONE NUMBER	
7. PRIOR	AUTHORIZATION NUMBER *	8. DATES COVERE	D BY THIS REQUEST			9. DOES CLIENT RESIDE I		10. GROUP HOME NAME -		
SYSTEM ASSIGNED FROM (MMDDYY) THR					GH (MMDDYY)	NURSING FACILITY?	ILITY? IF PATIENT RESIDES IN A GROUP HOME    NO			
1. ICD-10	O-CM DIAGNOSIS CODE <b>and</b> DESCRIP	l l TION (Must include Dia	Ignosis Code and Description,		nformation and Other Medi	ications presently prescribed)	EQUIPME	12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED		
							13. IND ICATI HOW LO	E LENGTH OF NECESSITY (IN NG WILL THIS EQUIPMENT BI	MONTHS AND YEARS) I.E. E NEEDED?	
					14. ESTIMATED COST OF EQUIPMENT					
SERV	ICES TO BE AUTHO	RIZED								
.5.	16.			17.		18.	19.	20.		
LINE NO.	DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR				PROCEDURE OR SUPPLY CODE		REQUESTED NUMBER OF SERVICES	AUTHORIZED NO. OF SERVICES (LEAVE BLANK ** )	APPROVED/DENIED (LEAVE BLANK ** )	
01										
02										
03										
04										
05										
21. PRIMARY CARE PHYSICIAN (PCP) NAME					22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)					
relephon	NE NUMBER		23. PCP PROVIDER NUMBER	२						
24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION					25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE					
26. REQU	ESTING PHYSICIAN SIGNATURE		27. DATE SI	GNED						
ELEPHON	NE NUMBER 28. REQUESTING PHYSICIAN PROVIDER NUMBER				TELEPHONE NUMBER  29. BILLING PROVIDER NUMBER					
If service	) ces are provided according to riately completed Medicaid cla	the manner preso	ribed by State of Color	rado Laws and R	egulations, reimburs	ement will be provided	for authorized se	ervices following submi	ssion of an	
30. COMM										
				ATTACH CODY	OE THIS DAD TO	~! ATM/C\ **				
		**	Ц	ATTACH COPY	OF THIS PAR TO (			**		
SIGNATUF	RE OF STATE AGENCY REPRESENTAT	IVE TT			DATE **	3	1. PA NUMBER BEING REVISED **			