

Iowa Department of Human Services
Iowa Medicaid Enterprise

REQUEST FOR PRIOR AUTHORIZATION

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last) (First) (Initial)			2. Patient Medicaid Identification No.		3. Date of Birth Month Day Year		4. Provider Taxonomy No.		
5. Dispensing Provider Name				6. Dates Covered by Request					
				From			To		
7. Provider Phone No		8. Provider Fax		9. Provider NPI		Mo.	Day	Year	
				Mo.	Day	Year	Mo.	Day	Year
10. Service Location Street Address				12. PRIOR AUTHORIZATION NO. (To be assigned by IME) Enter this number in the appropriate box when submitting the claim form for the services authorized.					
11. Service Location City, State, Zip									
13. Reasons For Request (Provide specific information and use additional sheet if necessary)									

SERVICES TO BE AUTHORIZED

14. Line No.	15. Procedure, Supply, Drug To Be Provided or NDC if applicable	16. Code, HCPCS, CPT or CDT	17. Units of Service	18. Authorized Units (leave blank)	19. Amount Requested	20. Authorized Amount (leave blank)	21. Status (leave blank)
01							
02							
03							
04							
05							
06							
07							
08							
09							

<p>22. IMPORTANT NOTE: In evaluating requests for prior authorization the need for treatment will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service by calling the ELVS line at 1-800-338-7752 (locally at 515-323-9639) or by accessing the Web Portal. Contact Provider Services at 800-338-7909 or (locally) 256-4609 for assistance in accessing the Web Portal.</p>					<p>23. Requesting provider</p> <p>_____</p> <p>Signature of Authorized Representative Date</p>		
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PRIOR AUTHORIZATION REVIEWER USE ONLY

24. MEDICAID SERVICES ARE HEREBY APPROVED DENIED FOR THE MEMBER UNDER TITLE XIX. THIS AUTHORIZATION APPLIES ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.

25. Comments or Reasons for Denial of Services

<p>*PROVIDER INFORMATION, PROCEDURE, SUPPLY, OR DRUG CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM. 470-0829 (Rev. 5/11)</p>	<p>26. Signature</p> <p>_____</p> <p>Iowa Medicaid Enterprise Date</p>
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