COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

LEAVE THIS AREA BLANK

OUTPATIENT SERVICES AUTHORIZATION REQUEST

1 ☐ PRIOR AUTHORIZATION 2 ☐ 1150 WAIVER (PROGRAM EXCEPTION)

PATIENT INFORMATION

3 RECIPIENT NUMBER	4 PATIENT LAST NAME	FIRST NAME	M.I.	5 BIRTHDATE	6 ☐ M ☐ F

PROVIDER / PRESCRIBER INFORMATION

7 PROVIDER NAME		8 PROVIDER ID	9 PROVIDER'S OWN REFERENCE NUMBER
10 GROUP NAME		11 GROUP ID NUMBER	
12 NAME OF REFERRING PRACTITIONER OR PRESCRIBER		13 LICENSE NUMBER	14 TELEPHONE NUMBER
15 PRACTITIONER'S / PRESCRIBER'S STREET ADDRESS	CITY	STATE	ZIP CODE
16 PRIMARY DIAGNOSIS	17 ICD/DSM CODE	18 SECONDARY DIAGNOSIS	19 ICD/DSM CODE

REQUESTED SERVICES

A DESCRIPTION OF SERVICES/SUPPLIES REQUESTED	FOR PRIOR AUTHORIZED SERVICES ONLY						FOR 1150 WAIVER ONLY		
	B PROCEDURE CODE	C MODIFIER MOD 1	MOD 2	MOD 3	MOD 4	D QUANTITY	E AMOUNT PER UNIT	F QUANTITY PER MONTH	G NUMBER OF MONTHS
20									
21									
22									
23									
24									
25									

26 A ESTIMATED LENGTH OF NEED (No. of Months): 1-99 (99= Lifetime) ▶ | B INITIAL DATE OF SERVICE ▶ | C BEGINNING DATE OF SERVICE FOR THIS REQUEST ▶

27 WHAT OTHER ALTERNATIVES HAVE BEEN TRIED OR USED TO MEET THIS PATIENT'S NEEDS?

28 CHECK THE BOX WHICH APPLIES TO THIS PATIENT'S CURRENT RESIDENTIAL STATUS:
☐ LONG TERM CARE ☐ MENTAL HEALTH ☐ RESIDENTIAL ☐ FOSTER CARE ☐ INPATIENT HOSPITAL ☐ HOME
☐ OTHER IF IN A FACILITY, PLEASE LIST THE NAME TO THE RIGHT_____

29 GIVE A NARRATIVE DESCRIPTION OF THE SPECIFIC SYMPTOMS OR ABNORMALITIES THE SERVICE/EQUIPMENT/SUPPLIES ARE INTENDED TO ALLEVIATE. PROVIDE THE MEDICAL JUSTIFICATION NEEDED FOR THE EVALUATION OF THIS REQUEST.

30 NUMBER OF ATTACHMENTS ▶

31 ☐ INITIAL REQUEST

32 ☐ RESUBMISSION OF PREVIOUSLY DENIED REQUEST
ENTER DENIED PA/PE REFERENCE NUMBER

I ATTEST THAT IN MY PROFESSIONAL JUDGEMENT, ACTING WITHIN THE SCOPE OF MY PROFESSIONAL TRAINING AND CERTIFICATION, THAT THE PRESCRIBED SERVICE AS DEFINED ON THIS FORM IS MEDICALLY NECESSARY AND THAT THE INFORMATION PROVIDED AND STATEMENTS MADE HEREIN ARE TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

I AUTHORIZE RELEASE OF INFORMATION RELATIVE TO THIS REQUEST

33 SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE

34 DATE

35 PRACTITIONER / PRESCRIBER SIGNATURE

36 DATE

DHS COPY

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