

## **Supplemental Prior Authorization Form**

This page is optional and meant to be used when a request exceeds more than four (4) Procedure Codes.

MEMBER INFORMATION			*Date of Birth (MMDDYYYY)
*Medicaid/Member ID Last Name, First			
AUTHORIZATION REQUEST			
*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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