absolute total care
Healthy Connections

Supplemental Prior Authorization Form

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

***INDICATES REQUIRED FIELD**

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
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days