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)

0	6	0	1	2	0	2	4

*Medicaid/Member ID

D	J	D	J	L	H	D	J	H	L	D	H	J	L	L	H

Last Name, First

D	J	H	L	J	H	L	J	H	J	H	L	H	L	J	H	L

AUTHORIZATION REQUEST

*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
D D L J D	0 6 1 0 2 0 2 4	0 6 1 0 2 0 2 4	J H G H D
K S H G K	0 6 1 5 2 0 2 4	0 6 0 1 2 0 2 4	J D J H H
D K G H G	0 6 0 1 2 0 2 4	0 6 0 1 2 0 2 4	J H D D D
F K F L J	0 6 0 1 2 0 2 4	0 6 1 8 2 0 2 4	J H D G K
K H S G K	0 6 0 1 2 0 2 4	0 6 0 9 2 0 2 4	D J H H G
L J D L G	0 6 1 5 2 0 2 4	0 6 2 0 2 0 2 4	J H K H G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G

Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
K S H G K	0 6 1 5 2 0 2 4	0 6 0 1 2 0 2 4	J D J H H
D K G H G	0 6 0 1 2 0 2 4	0 6 0 1 2 0 2 4	J H D D D
F K F L J	0 6 0 1 2 0 2 4	0 6 1 8 2 0 2 4	J H D G K
K H S G K	0 6 0 1 2 0 2 4	0 6 0 9 2 0 2 4	D J H H G
L J D L G	0 6 1 5 2 0 2 4	0 6 2 0 2 0 2 4	J H K H G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G
S G H S G	0 6 1 5 2 0 2 4	0 6 1 5 2 0 2 4	S G H S G

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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