Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years Old

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at: http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html

This form MUST accompany your Prior Approval request for EPSDT consideration via submission through provider portal, fax or mail. **DO NOT** send this form to CCH without an accompanying Prior Approval request. It will not be processed without a Prior App Request.

I. **Recipient Information:** This must be completed by a physician, licensed clinician, or other provider.

Name: _____

Date of Birth: __/__/____(mm/dd/yyyy) Medicaid ID Number:_____

Address:

_____

_____

_____

II. **Medical Necessity:** All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: _____ Provider Name: _____

NPI: _____ NPI: _____

Address: _____ Address: _____

_____ _____

_____ _____

Telephone: (___) _____ Telephone: (___) _____

Fax: (___) _____ Fax: (___) _____

Requested procedure, product or service: _____

CPT/HCPCS Code: _____/_____

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.):_____

_____

_____

What is the recipient's health history? (Include chronic illness.): _____

_____

_____

_____

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.):

_____

_____

_____

What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals and the recipient's response to treatment(s).): _____

_____

_____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem.) This description must include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems:_____

_____

_____

_____

_____

_____

_____

_____

Is this request for an experimental or investigational treatment: ☐ Yes ☐ No
If yes, provide name and protocol number: _____

Is the requested product, service or procedure considered to be safe? ☐ Yes ☐ No

_____

_____

Is the requested product, service or procedure effective? ☐ Yes ☐ No
If no, please explain: _____

_____

_____

_____

Are there alternatives to the product, procedure or service requested that would be more cost effective but similarly medically effective? ☐ Yes ☐ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available: _____

_____

_____

_____

What is the expected duration of treatment? _____

_____

_____

_____ _____

Requestor's Signature & Credentials **Date**