Print Reset

DEPARTMENT OF HUMAN SERVICES

Prime THERAPEUTICS™

Minnesota Health Care Programs
Medical Authorization Form

Fax this form to 866-390-2778. A fax cover sheet is not required.

REQUESTOR INFORMATION

Requestor Name: _____

Requestor Phone Number: _____

Requestor Affiliation (for drug authorization only): ☐ Pharmacy ☐ Prescriber

AUTHORIZATION INFORMATION

Authorization Type: Medical Services

Is This a Change to an Existing Authorization? ☐ Yes ☐ No

If Yes, What Is the Prior Authorization (PA) Number? _____

Start Date: _____ End Date: _____

PAY-TO PROVIDER INFORMATION

Pay-to Provider Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Provider Phone: _____ Provider Fax: _____

Provider NPI: _____ Taxonomy Code: _____

MEMBER INFORMATION

Member Last Name: _____ Middle Initial: _____

Member First Name: _____

Date of Birth: _____ ID Number: _____

ORDERING OR REFERRING PROVIDER INFORMATION

Provider Name: _____

Provider NPI: _____

Provider Phone: _____ Provider Fax: _____

Member's Full Name: _____

SERVICE LINE INFORMATION

Will the medication be administered in a clinic or outpatient facility? ☐ Yes ☐ No

Procedure Code (HCPCS): _____

Modifier (Up to 4): _____ _____ _____ _____

Diagnosis Code(s) _____ Drug Name: _____

Drug Strength: _____ HCPCS Units per Dose: _____

Dosing Frequency: _____ Total HCPCS Units Requested: _____

Route of Administration: _____

Start Date: _____ End Date: _____

Total Submitted Charges: _____

Rendering Provider NPI: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units per Dose: _____ Dosing Frequency: _____

Total Submitted Charges: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units per Dose: _____ Dosing Frequency: _____

Total Submitted Charges: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units per Dose: _____ Dosing Frequency: _____

Total Submitted Charges: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units per Dose: _____ Dosing Frequency: _____

Total Submitted Charges: _____

Service Description or Comments:

☐ _____

Attachments – Include supporting documentation as necessary.

Member's Full Name: _____

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

For most **medical** services and **equipment and supplies**, send all supporting documentation to KEPRO:

Mail: KEPRO
Attention: MN Medicaid
2810 N Parham Road, Suite 305
Henrico, VA 23294
Fax: 866-889-6512
Phone: 866-433-3658

For **physician administered drugs** (J-codes) **only**, send all supporting documentation by fax or mail:

Mail: Prime Therapeutics Pharmacy LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 844-575-7887

Fax this form to 866-390-2778.

Member's Full Name: _____

MHCP Authorization Form Instructions

Complete one form per recipient

View general Claims Submission guidelines and refer to MHCP authorization policies.

REQUESTOR INFORMATION

- **Requestor name:** Enter the first and last name of the person requesting this authorization.
- **Requestor phone number:** Enter the requestor's phone number.
- **Requestor affiliation:** For physician administered drug authorizations, select whether the requestor is affiliated with a pharmacy or prescriber.

AUTHORIZATION INFORMATION

- **Authorization type:** Place an "X" in the appropriate Authorization Type box.
- **Change to existing authorization:** If you are making a change to an existing authorization, mark the Change for PA # box and print the 11-digit authorization number you wish to update.
- **Start date:** Enter the first date of service (MM/DD/YYYY) for this authorization request. If approved, this will be the effective date of the authorization. If service has already been provided, enter the date the service began.
- **End date:** Enter the last date of service (MM/DD/YYYY) for the authorization request. If service has already been provided and will not continue, enter the last date the service was provided.

PAY-TO PROVIDER INFORMATION

- **Pay-to provider name:** Enter the name of the pay-to provider for the service.
- **Address:** Enter the provider's street address, city, state and zip code. For consolidated providers, enter the address for the location where the service was performed.
- **Phone number:** Enter the provider's phone number.
- **Fax number:** Enter the provider's fax number.
- **NPI:** Enter the provider's NPI.
- **Taxonomy code:** For consolidated providers, enter the provider's taxonomy code, when applicable.

MEMBER INFORMATION

- **Last name:** Enter the recipient's last name.
- **First name:** Enter the recipient's first name.
- **MI:** Enter the recipient's middle initial (if known).
- **ID number:** Enter the recipient's 8-digit MHCP ID number.
- **Date of birth:** Enter the recipient's birth date in MM/DD/YYYY format.

Member's Full Name: _____

ORDERING/REFERRING PROVIDER INFORMATION

- **Name:** Enter the name of the provider who ordered, referred or prescribed the service.
- **NPI:** Enter the provider's 10-digit NPI.
- **Phone number:** Enter the provider's phone number.
- **Fax number:** Enter the provider's fax number.

SERVICE LINE INFORMATION

- **Procedure code:** Enter the appropriate HCPCS code for the procedure/service you are requesting for authorization.
- **Modifier:** Enter any appropriate HCPCS modifier(s) for the procedure/service you are requesting for authorization.
- **Diagnosis code(s):** Enter the recipient's ICD diagnosis code(s) relevant to the procedure/service for which you are requesting authorization.
- **Start date:** Enter the first date of service (MM/DD/YYYY) for the procedure listed.
- **End date:** Enter the last date of service (MM/DD/YYYY) for the procedure listed.
- **HCPCS Units per Dose:** Enter the number of HCPC units per dose.
- **Total HCPCS Units Requested:** Enter the total number of procedure/service units.
- **Rendering Provider NPI:** Enter the 10-digit NPI of the rendering provider if different than the NPI listed under Provider Information above.
- **Total Submitted Charges:** Enter the total reimbursement amount (rate multiplied by quantity/units) you are requesting for this service.
- **Service description/comments:** Enter comments and/or description of the service to be provided.
- **Sign and date the form.**