One request per form. Separate approvals must be obtained for the facility and the provider.

PED-I-CARE MEDICAL AUTHORIZATION REQUEST FORM

Fax requests to (866) 256-2015 • For questions call (800) 492-9634

eINFOsource Provider Portal: https://cms.einfosource.med3000.com

Ped-I-Care website: http://pedicare.pediatrics.med.ufl.edu/

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Program: ☐ **Title 19 MMA-CMS Plan** ☐ **Title T21**

Request Type: ☐ **Standard** ☐ **STAT*** ☐ **Retro** (service already provided) ☐ **ER or Observation Stay Notification**

**Standard timeframe could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function.*

Member: ___________________________ DOB: __________ Member ID#: _________________ Age: _____ Gender: ____

	Requesting Provider	Requested Provider/Facility	PCP (If not already listed)
Provider Name			
Specialty			
Tax ID #			
Contact Name			
Phone #			
Fax #			

Diagnosis Code(s):________________________________ **CPT/HCPCS Code(s), if applicable:** ________________________________

AUTHORIZATION INFORMATION – Requests require the submission of supporting clinical documentation.

Provider/Facility is: ☐ Participating ☐ Non-Participating (Include address, contact info, NPI #, and for T19 the Medicaid #)

Date of Admit/Service: _________________ ☐ Elective (Includes scheduled) ** ☐ Emergent (in 24 hours)

Requested Dates: __________________ through _______________ **Total:** ___________ ☐ Days ☐ Weeks ☐ Months

Procedure: ____

☐ Inpatient Surgery/Services ☐ Outpatient Surgery/Services ** ☐ Transplantation & Related Care

☐ Experimental/Investigational Treatment ☐ Out-of Network Request for: ____________________________________

☐ Other ____

Items/Supplies **

☐ Augmentative Communication System/Device

☐ DME:_____________________________________

☐ Orthotics/Prosthetics:_____________________

Hearing: ☐ Hearing Aids ☐ Cochlear Implant

Nutritional Supplements: (Include forms and order)

☐ Enteral ☐ TPN

Vision: ☐ Contact Lenses ☐ Specialty Glasses

Services/Procedures +

☐ Diagnostic Imaging of: ____________________

☐ MRI ☐ MRA ☐ CT Scan ☐ PET Scan

☐ Genetic Testing *** (Include Supplemental Form)

☐ Oral Surgery **

☐ Orthodontia ** (Include Medicaid score sheet and films and/or photos if score doesn't meet guidelines)

Days/Week: _____ **Units/Day:** _____ **Total Units:** _____

Choose one service type and include a signed plan of care.

Home Health Services ☐ Home Health Aide

PDN: ☐ LPN ☐ RN ☐ Home Infusion

Is another child in the home already receiving home health services? ☐ Yes ☐ No

Therapy ☐ Physical ☐ Occupational

☐ Speech ☐ Respiratory

Applied Behavioral Analysis (ABA) Therapy

T21 – Fax to Concordia: (305) 514-5321 or (855)698-7790

Questions: (877) 698-7789 option 2, option 1

T19 - *Request through the Local Medicaid Area Office*

Prescribed Pediatric Extended Care (PPEC)

T21 - # Full Days: _________ # Half Days: _________

T19 - *Request through eQHealth @ 1-855-444-3747*

Transportation (For routine, non-emergent transportation to medical appointments)

T21 - *Call TMS @ 1-855-739-5986 to request services* **T19 -** *Call TMS @ 1-866-411-8920 to request services*

**** For services that have a by report (BR) or prior authorization (PA) indicator on the Medicaid Fee Schedule.**

Updated: 8/5/2016

***** If not on Medicaid fee schedule, or if genetic testing is with an out-of-network provider.**

+ MRIs and CTs do not require PA if the diagnosis code is listed in Appendix D of the Practitioner Services Coverage and Limitations Handbook. For diagnoses not listed, PA is required.