DEPARTMENT OF HUMAN SERVICES

DHS-4695-ENG 1-19

Minnesota Health Care Programs (MHCP)

Authorization Form

DOCUMENT CONTROL NUMBER (FOR INTERNAL USE ONLY)

Requestor Information

REQUESTOR NAME	REQUESTOR PHONE NUMBER	REQUESTOR AFFILIATION (for drug authorization only)
		◯ Pharmacy ◯ Prescriber

Authorization Information

AUTHORIZATION TYPE	CHANGE TO EXISTING AUTHORIZATION	START DATE	END DATE
◯ Medical Services ◯ Medical Equipment and Supplies	☐ Change for PA# _____		

Pay-to Provider Information

PAY-TO PROVIDER NAME				
ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	NPI OR UMPI	TAXONOMY CODE	

Recipient Information

LAST NAME	FIRST NAME	MI	ID NUMBER	DATE OF BIRTH

Ordering or Referring Provider Information

NAME	NPI OR UMPI	PHONE NUMBER	FAX NUMBER

Service Line Information

PROCEDURE CODE	MODIFIER (UP TO 4)				DIAGNOSIS CODE(S)	MODEL NUMBER
START DATE	END DATE	RATE OR CHARGE	QTY OR UNITS	RENDERING PROVIDER NPI OR UMPI	TOTAL AMOUNT	
SERVICE DESCRIPTION OR COMMENTS						

PROCEDURE CODE	MODIFIER (UP TO 4)				DIAGNOSIS CODE(S)	MODEL NUMBER
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SERVICE DESCRIPTION OR COMMENTS

	SIGNATURE	DATE
Include supporting documentation as necessary.		

For most Medical services and Equipment and Supplies, send all supporting documentation to KEPRO at:

Send to: 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 to:

MHCP Prescription Drug Prior Authorization Review Agent
c/o Health Information Designs, Inc.
391 Industry Drive
Auburn, AL 36832
Fax: 866-648-4574

MHCP Authorization Form Instructions

Complete one form per recipient.

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/UMPI: Enter the provider's NPI/UMPI.

Taxonomy code: For consolidated providers, enter the provider's taxonomy code, when applicable.

Recipient 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.

Ordering/Referring Provider Information

Name: Enter the name of the provider who ordered, referred or prescribed the service.

NPI/UMPI: Enter the provider's 10-digit NPI or UMPI.

Phone number: Enter the provider's phone number.

Fax number: Enter the provider's fax number.

Service Line Information

Procedure code: Enter the appropriate CPT/HCPCS code for the procedure/service you are requesting for authorization.

Modifier: Enter any appropriate CPT/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.

Model number: If you are requesting authorization for a medical supply, enter the model number or UPC. If the medical supply does not have a model number or UPC, leave blank.

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.

Rate: Enter your usual and customary charge or requested rate of payment per unit.

Qty/Units: Enter the total number of procedure/service units.

Rendering provider NPI/UMPI: Enter the 10-digit NPI or UMPI of the rendering provider if different than the NPI/UMPI listed under Provider Information above.

Total amount: Enter the total reimbursement amount (rate multiplied by qty/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.

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