



PRIOR AUTHORIZATION FORM

INSTRUCTIONS: Please call or fax the following information to Children’s Mercy Family Health Partners (CMFHP). CMFHP will verify benefits, eligibility and provider network status and make you aware of non-covered services. Within 48 hours or two business days CMFHP will call you with a determination. Authorization numbers issued for covered services should be included on claims submitted.

Payment is subject to eligibility status and benefits that are in effect at the time services are provided. CMFHP will not assume financial responsibility for services where prior notification does not occur according to CMFHP policies. You must notify CMFHP if additional services or an extension is needed.

PLEASE CHECK ONE: Urgent Routine **Prior Authorization #** _____ **(if applicable)**

Date Form Completed	Member Name
Member ID # & DOB	Service Start Date/Requested Visits/Treatment Duration
Requesting Physician/Practitioner	Provider of Services
Diagnosis/Treatment	Admission Facility (if appropriate)

Please complete the information below and attach any necessary supporting clinical documentation needed for service consideration. Please include the specific service and number of visits, if applicable. Please refer to your CMFHP Provider Administration Manual, Provider Quick Guide, or the CMFHP Website.

Service or Item Requested: _____

Length of need or # of visits/items: _____

CPT/HCPCS Code(s): _____

DME-Include code and description of item(s): _____

Request: NEW _____ EXTENSION _____

Physician’s Order (Attach Copy): _____

Medical Necessity Documentation (Attach Documentation): _____

Home Health – Copy of Order and Plan of Care: _____

Therapy – Copy of Evaluation and Plan of Care: _____

Contact Name (please print): _____

Contact Telephone: _____ Fax: _____