

Prior Authorization (Non-Pharmacy) Request



Date: _____

MFC - District of Columbia Fax: (202) 243-6258

Enrollee Name: *(Please print)* _____ DOB: _____

Enrollee MedStar ID #: _____ Medicaid ID #: _____

(ID begins with 61...)

Provider Name/Office: _____ NPI# _____

Provider Phone: _____ Provider Fax: _____

Contact Person Name: _____

Contact Phone w/ext: _____ Contact Fax: _____

MUST CHECK ONE: Inpatient ☐ Outpatient/ Home ☐

Date(s) of Service: _____

Facility/Vedor Name: _____ NPI# _____

Diagnosis Code(s) /ICD-10: _____

CPT Code/HCPs: _____

Units _____

*****Please include all of the following documents that apply*****

- Clinical/Office Notes
- X-Rays/MRI/CT/PET Scan or other applicable radiology studies
- Lab results

☐ Approved

☐ Denied

MFC Reviewer: _____