



Prior Authorization Form Instructions

The preferred method of prior authorization submission is via the Qualitrac provider portal. Submission through the portal provides transparency into the review process, and, allows for faster notifications of outcomes. The link below allows you to log in to the Qualitrac portal and/or register for the portal.

<https://msmedicaid.telligen.com/>

In the event submission via the portal is not possible, we will accept prior authorizations by fax. Telligen is introducing a standardized authorization form. This form can be used to submit a prior authorization request for review along with the necessary clinical documentation. This form is designed to serve as a standardized prior authorization for all review types. It is intended to streamline the submission process for providers.

The fax number is: 800-524-5710

Complete the fields below on the authorization form. The supplemental form is available if there are additional diagnosis or procedures that need to be requested.

The required documentation, discussed in the provider training, will need to be submitted with this form. Failure to complete all fields of the form or to submit the required clinical documentation may/will result in a technical denial or the inability to process your request.



COMPLETE ALL INFORMATION ON THE "PRIOR AUTHORIZATION FORM".
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Date of Request: Click or tap to enter a date.

MEMBER INFORMATION

Member Name: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date.

Medicaid ID Number: Click or tap here to enter text.

REQUEST INFORMATION

Review Type: Choose an item.

Place of Service: Choose an item.

Type of service: Choose an item.

Choose an item.

Timing: Choose an item.

Service Start Date/Admission Date: Click or tap to enter a date.

Service End Date/Discharge Date: Click or tap to enter a date.

Diagnosis 1 ICD 10 Code: Click or tap here to enter text.

Diagnosis 2 ICD 10 Code: Click or tap here to enter text.

Diagnosis 3 ICD 10 Code: Click or tap here to enter text.

Diagnosis 4 ICD 10 Code: Click or tap here to enter text.

1st Procedure Code: Click or tap here to enter text. **2nd Procedure Code:** Click or tap here to enter text.

3rd Procedure Code: Click or tap here to enter text. **4th Procedure Code:** Click or tap here to enter text.

If additional procedure/HCPCS codes are required, please attach a separate sheet of paper.

PROVIDER INFORMATION

Treating Provider Name: Click or tap here to enter text.

Treating Provider NPI: Click or tap here to enter text.

Treating Provider Address: Click or tap here to enter text.

Ordering Provider Name: Click or tap here to enter text.

Ordering Provider NPI: Click or tap here to enter text.

Ordering Provider Address: Click or tap here to enter text.

Treating Facility Name: Click or tap here to enter text.

Treating Facility NPI: Click or tap here to enter text.



Treating Facility Address: Click or tap here to enter text.

DME Company Name:Click or tap here to enter text.

DME Company NPI:Click or tap here to enter text.

DME Company Address: Click or tap here to enter text.

Please attach applicable clinical information to support the need for services including but not limited to Physician orders, plan of care, certificate of medical need, progress notes, evaluations, discharge summary, imaging results, lab results, etc.

Supplemental Information

Member Name: Click or tap here to enter text. **Member DOB:** Click or tap here to enter text.

Additional Diagnosis:Click or tap here to enter text. **Additional Diagnosis:**Click or tap here to enter text.

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Procedure Code:Click or tap here to enter text.

Units/Visits:Click or tap here to enter text.

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