Prior Authorization Change Request Form

Submit by email or fax at: **Email**: MSMedicaidUM@Telligen.com | **Fax**: 800-524-5710

The PA Change Request Form is to be used for PA requests that are in progress or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs.

Member Information	
Member Name:	
Medicaid ID:	

Provider Information	
Contact Name:	
NPI:	
Phone Number:	

Prior Authorization Number	

Reason for Change: **Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.** **Examples:** *Add/Change Modifier: Add "RR" to "E1088"* *Correct Date(s) of Service: Change requested effective date from 08/01/2023 to 10/01/2023*	
Add/Change Modifier:	
Correct Number of Service(s):	
Correct Place of Service:	
Correct Diagnosis Code(s):	
Correct Date(s) of Service:	
Correct NPI:	
Other: (Please Explain)	
Comments:	

Note: Telligen cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. This form must be received with **90 days** of the date of the approval on the PA decision letter.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Telligen. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.