



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.

Prior Authorization Form



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

Date of Request:

MEMBER INFORMATION

Member Name:

Date of Birth:

Medicaid ID Number:

REQUEST INFORMATION

Review Type: Choose an item.

Place of Service:

Type of service: Choose an item.

Timing:

Service Start Date/Admission Date:

Service End Date/Discharge Date:

Diagnosis 1 ICD 10 Code:

Diagnosis 2 ICD 10 Code:

Diagnosis 3 ICD 10 Code:

Diagnosis 4 ICD 10 Code:

1st Procedure Code:

Units/Visits/Modifiers:

2nd Procedure Code:

Units/Visits/Modifiers:

3rd Procedure Code:

Units/Visits/Modifiers:

4th Procedure Code:

Units/Visits/Modifiers:

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

Treating Provider Name:

Treating Provider NPI:

Treating Provider Address:

Ordering Provider Name:

Ordering Provider NPI:

Ordering Provider Address:

Treating Facility Name:

Treating Facility NPI:

Treating Facility Address:

DME Company:

DME Company NPI:

DME Company Address:



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:

Member DOB:

Additional Diagnosis:

Additional Diagnosis:

Additional Diagnosis:

Additional Diagnosis:

Procedure Code:

Units/Visits/Modifiers:

Procedure Code:

Units/Visit/Modifiers:

Procedure Code:

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