

# Prior Authorization Change Request Form



Submit by email or fax at: **Email:** [MSMedicaidUM@Telligen.com](mailto: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.**

<b>Member Information</b>	
Member Name:	
Medicaid ID:	

<b>Provider Information</b>	
Contact Name:	
NPI:	
Phone Number:	

<b>Prior Authorization Number:</b>	
<b>Case ID Number</b>	
<b>Request ID Number:</b>	
<b>Date of Request:</b>	
<b>Reason for Change:</b> <b>Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.</b> <b>Examples:</b> 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)	
<b>Comments:</b>	

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 within **90 days** of the date of the approval on the PA decision letter.

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