

Universal Newborn Prior Authorization Form – Pediatric Offices

Out-of-network pediatric providers must provide this information to obtain an authorization for services rendered in the office during the first 60 days after discharge. Authorization should be requested by close of the next business day. For questions, contact the plan at the associated phone number.

***Fax the COMPLETED form OR call the plan with the requested information.**

Absolute Total Care

P: 866-433-6041
F: 866-918-4451
www.absolutetotalcare.com

BlueChoice HealthPlan

P: 866-902-1689
F: 800-823-5520
www.bluechoicescmedicaid.com

First Choice by Select Health

P: 888-559-1010
F: 866-368-4562
www.selecthealthofsc.com

Unison Health Plan

P: 800-366-7304
F: 866-841-9336
www.unisonhealthplan.com

Patient's Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone(s) _____ Medicaid Number _____ MCO ID Number _____

Mom's Name _____ Mom's Medicaid Number _____
First Middle Last

Mom's SSN _____

Secondary Coverage:

Plan _____ ID# _____ Group # _____

Policy Holder _____ DOB _____ Relationship to patient _____ Employer _____

EPSDT and IMMUNIZATION

99381 (EPSDT New) 99391 (EPSDT Est.) 1 Visit 2 Visits

90471 DOS: _____ Immunization Administered: _____
 90472 DOS: _____ Immunization Administered: _____
 90473 DOS: _____ Immunization Administered: _____

EIM Non-EPSDT

CPT: _____ Dx: _____ DOS: _____ CPT: _____ Dx: _____ DOS: _____

LABS **CLIA CERTIFICATE NUMBER** _____

CPT: _____ DOS: _____ CPT: _____ DOS: _____
 CPT: _____ DOS: _____ CPT: _____ DOS: _____
 CPT: _____ DOS: _____ CPT: _____ DOS: _____

OTHER

17250 DOS: _____ 54160 DOS: _____ 96150 DOS: _____
 51701 DOS: _____ 94640 DOS: _____ 96152 DOS: _____
 54150 DOS: _____ 94760 DOS: _____ 97802 DOS: _____
 CPT: _____ DOS: _____ CPT: _____ DOS: _____

Practice Name: _____ Practice NPI: _____
Attending Physician (last name, first name): _____ NPI: _____
Contact Person: _____ Phone: _____ Fax: _____

Plan Point of Contact: _____ Date Plan Called: _____ Time of Call: _____
Plan Reference/Confirmation Number: _____

FOR MCO USE ONLY:

Approved Denied Authorization # _____ Date of Notification to Pediatric Office: _____
Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.