



NEW HAMPSHIRE MEDICAID

272PDN FFS i
10/2018

**REQUEST FOR SERVICE AUTHORIZATION
FOR DIAGNOSTIC IMAGING**
Instructions for filling out this form are attached.
(Fee-for-Service (FFS) Program Only –
Not for Managed Care program use)

For State use only. Administrative **APPROVAL** per Medical Director
Date: _____ By: _____
Dates of Service: _____
EPSDT: _____ SA #: _____

PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)**

RECIPIENT INFORMATION

RECIPIENT NAME: _____ **DATE OF BIRTH:** _____
RECIPIENT MEDICAID ID #: _____ **DIAGNOSIS CODES:** _____
ALTERNATE INSURANCE PLAN NAME: _____

PROVIDER INFORMATION

DATE(S) OF SERVICE: _____ **CONTACT PERSON:** _____
TELEPHONE # _____ **FAX #:** _____
PERFORMING FACILITY: _____ **PERFORMING FAC. FAX #:** _____
PERFORMING FACILITY MEDICAID ID # _____

| Requested Procedure | CPT Code and Modifier | w/ contrast | w/o contrast | w/ & w/o contrast | Date of Service |
|---------------------|-----------------------|-------------|--------------|-------------------|-----------------|
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PHYSICIAN'S ORDER AND LETTER OF MEDICAL NECESSITY

Pursuant to He-W 569.06© Request for Prior Authorization for Diagnostic Imaging, and clinical information supporting the medical necessity for the request, including, but not limited to, the medical care plan, relevant diagnostic tests, and progress notes must be attached.

For the items listed above: (please check and include all.)
 I certify that I have obtained a Physician's order and a LMN pursuant to He-W 569.06 (c).
 I have attached medical records to support the medical necessity of this diagnostic imaging.

Signature *Date*

Printed Name *Title*



**INSTRUCTIONS FOR DIAGNOSTIC IMAGING:
FORM 272X FFS REQUEST FOR SERVICE AUTHORIZATION
FOR DIAGNOSTIC IMAGING**

This form must be filled out pursuant to He-W 569.06 (c) The ordering practitioner shall initiate the service authorization process on behalf of the recipient by submitting a completed Form 272X, Request for Service Authorization for Diagnostic Imaging (January 2014), and clinical information supporting the medical necessity for the request, including, but not limited to, the medical care plan, relevant diagnostic tests, and progress notes, to the State by mail, or fax.

Please note that before this form is filled out, **it is your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections of the new form are the Recipient Information and Provider Information and should be filled out accordingly. Note that the ordering physician and the rendering facility will have two different Medicaid ID numbers.

The next section is what you are requesting. Fill in a description of the diagnostic test, the Procedure Code, with or without contrast and the date of service.

The section following is the legal information with references to the Medicaid rule, for your convenience. The signature should be that of the person making out the form.

Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Fax all documentation and the Service Authorization Request form to 603-271-8194. You will receive a fax from the state with the approval information or a request for more information.

Once the Request for Service Authorization has been approved by the State it is sent to the Fiscal Agent, Conduent, to create the authorization. Conduent has three business days to create and mail the authorization to the performing provider. If you have questions, please call Conduent at 1-866-291-1674.

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL

129 Pleasant St ■ Concord, NH 03301 ■ FAX: (603) 271-8194