



NC Medicaid Request for Prior Approval CMN/PA



Recipient Information

NC Medicaid-372-131

1. Recipient Last Name: _____ 2. First Name: _____
 3. Recipient ID # _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

V1.0 Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. The payer for this service is: _____ Medicaid:

Provider Information

7. Requesting Provider #: _____ NPI: Atypical: 8. Taxonomy: _____
 9. Address: _____ 10. Nine Digit Zip Code: _____
 11. Billing Provider # (if different from requesting): _____ NPI: Atypical: 12. Taxonomy: _____
 13. Address: _____ 14. Nine Digit Zip Code: _____
 15. Rendering Provider # (if different from billing): _____ NPI: Atypical: 16. Taxonomy: _____
 17. Address: _____ 18. Nine Digit Zip Code: _____
 Requester Contact Information Name: _____ Phone #: _____ Ext: _____

Medical and Functional Status

19. **Condition:** Stable: Unstable: Height: _____ Weight: _____
 20. **Prognosis:** Terminal: Poor: Guarded: Fair: Good: Excellent:
 21. **Patient:** Requires positioning not feasible in ordinary bed: Unattended for long periods of time: Lives alone:
 22. **Equipment:** Necessary to retard deterioration of condition: Necessary for function: Specify _____ Length of need: _____
 23. **Mental:** Oriented: Forgetful: Disoriented: Agitated: Comatose: Depressed: Lethargic: Infant: Other: _____
 24. **Neurological:** Muscle Tone: Normal: Increased: Decreased: Fluctuating:
 Sensation: Normal: Abnormal: Specify: _____
 25. **Respiratory:** Normal: SOB on minimal exertion: Tracheostomy:
 O2: Flow Rate: _____ Frequency: _____ Test Date: _____ Results: _____
 26. **Skin:** Normal: Other: Specify: _____ Decubiti: Specify: _____
 27. **Ambulatory:** Complete bedrest: Up as tolerated:
 Transfers bed-chair (indep): Transfers bed-chair (w/assistance): Confined to wheelchair? Hours per day: _____
 Walks unassisted: Walks with assistive device: Specify: _____ Max distance walked: _____
 28. Can place of residence physically accommodate equipment being requested? Yes No
 29. Patient's status will be monitored by physician while assistance is provided? Yes No
 30. Medical Necessity of equipment: _____

Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Requesting Provider's Signature _____ Date _____ Physician, PA, Nurse Practitioner Signature _____ Date _____
 Fax this form to: (855) 710-1964
 3.2024