



NC DMA Request for Prior Approval



Recipient Information

DMA372-118

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

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (<input checked="" type="checkbox"/>)
1			
2			
3			
4			
5			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

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: _____

Service Information

19. Procedure Code: _____ 20. Modifier(s): 1 ___ 2 ___ 3 ___ 4 ___ 21. Place of Service: _____
 22. Description of Service to be Performed: _____

 23. Requested Units: _____ 24. Unit Type: _____ 25. Retroactive Request?
 26. Requested Begin Date: _____ 27. Requested End Date: _____
 28. Requested Frequency: _____ 29. Frequency Period: _____
 30. Requested Duration: _____ 31. Duration type: _____

Additional Information

(Include any additional information related to this request)

Requesting Provider's Signature: _____ Date: _____

Fax this form to CSC at: (855) 710-1964