



## Non-Covered State Medicaid Plan Services Request Form for Recipients *under 21 Years Old*

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:  
<https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec440-170.pdf>

This form may be found at <https://providers.partnersbhm.org/>

For products that require Prior Authorization, this form MUST accompany your Prior Approval request for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) consideration via submission through the departments noted below. You may use additional sheets to supply any other information you think would be helpful. **Include evidence-based literature, if available.**

Send the completed form to Partners Health Management:

**Behavioral Health, Intellectual/Development Disorders (I/DD), Traumatic Brain Injury (TBI) Requests:**  
[BHIDDManualAuthorizations@PartnersBHM.org](mailto:BHIDDManualAuthorizations@PartnersBHM.org).

**Physical Health and Physician Administered Drug Program (PADP) Requests:**  
[PHManualAuthorizations@PartnersBHM.org](mailto:PHManualAuthorizations@PartnersBHM.org); Physical Health Fax: 336-527-3208

**Outpatient Pharmacy Requests:** Pharmacy Prior Approval (PA) Phone Number: 1-877-817-2184; Pharmacy PA Fax: 866-255-7569

**I. Recipient Information:** This must be completed by a physician, licensed clinician, or other provider.

Name: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Address: \_\_\_\_\_

**II. Medical Necessity:** All requested information, including Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor name: \_\_\_\_\_

NPI: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Requested procedure, product or service: \_\_\_\_\_

\_\_\_\_\_

Provider name: \_\_\_\_\_

NPI: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

CPT/HCPCS codes: \_\_\_\_\_

\_\_\_\_\_

**In what capacity have you treated the recipient?** (Include how long you have cared for the recipient and the nature of the care.)

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**What is the recipient's health history?** (Include chronic illness.)

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**What are the recent diagnoses related to this request?** (Include the onset, course of the disease and the recipient's current status.)

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**What treatment has been given for the diagnoses above?** (Include previous and current treatment regimens, duration, treatment goals and the recipient's response to treatments.)

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**Describe how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness or condition.** (Include how the procedure, product or service will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.)

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**Is this request for an experimental or investigational treatment?**

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Yes

☐

No

If yes, provide name and protocol number: \_\_\_\_\_

**Is the requested procedure, product or service considered to be safe?**

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Yes

☐

No

If no, please explain: \_\_\_\_\_

**Is the requested procedure, product or service effective?**

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Yes

☐

No

If no, please explain: \_\_\_\_\_

**Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective?**

☐

Yes

☐

No

If yes, specify what alternatives are appropriate for the recipient and provide evidence-base with this request, if available: \_\_\_\_\_

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What is the expected duration of treatment? \_\_\_\_\_

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Requestor's Signature and Credentials

Date