

## Prior Authorization (Non-Pharmacy) Request



Date: \_\_\_\_\_

**MFC - Maryland Fax: (410) 933-2274**

Member Name: *(Please print)* \_\_\_\_\_ DOB: \_\_\_\_\_

Member MedStar ID #: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

*(MD ID begins with 91...)*

Provider Name/Office: \_\_\_\_\_ NPI# \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_

Contact Phone w/ext: \_\_\_\_\_ Contact Fax: \_\_\_\_\_  
(If different from above)

**MUST CHECK ONE:** Inpatient  Outpatient

Date(s) of Service: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Diagnosis Code(s) /ICD-10: \_\_\_\_\_

CPT Code/HCPS: \_\_\_\_\_

\_\_\_\_\_ Units \_\_\_\_\_

**\*\*\*Please include all of the following documents that apply\*\*\***

- Clinical/Office Notes
- X-Rays/MRI/CT/PET Scan or other applicable radiology studies
- Lab results

Approved  Denied MFC Reviewer: \_\_\_\_\_