Universal Newborn Prior Authorization Form – Pediatric Offices

Out-of-network pediatric providers must provide this information to obtain an authorization for services rendered in the office during the first 60 days after discharge. Authorization should be requested by close of the next business day. For questions, contact the plan at the associated phone number.

***Fax the COMPLETED form OR call the plan with the requested information.**

☐ **Absolute Total Care**
P: 866-433-6041
F: 866-918-4451
www.absolutetotalcare.com

☐ **BlueChoice HealthPlan**
P: 866-902-1689
F: 800-823-5520
www.bluechoicescmedicaid.com

☐ **First Choice by Select Health**
P: 888-559-1010
F: 866-368-4562
www.selecthealthofsc.com

☐ **Unison Health Plan**
P: 800-366-7304
F: 866-841-9336
www.unisonhealthplan.com

☐ **WellCare Health Plans**
P: 888-588-9842
F: 866-354-8709
www.wellcare.com

Patient's Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone(s) _____ Medicaid Number _____ MCO ID Number _____

Mom's Name _____ Mom's Medicaid Number _____
First Middle Last

Mom's SSN _____

Secondary Coverage:

Plan _____ ID# _____ Group #_____

Policy Holder _____ DOB _____ Relationship to patient _____ Employer _____

☐ *EPSDT and IMMUNIZATION*

☐ 99381 (EPSDT New) ☐ 99391 (EPSDT Est.) ☐ 1 Visit ☐ 2 Visits

☐ 90471 DOS:_____ Immunization Administered:_____
☐ 90472 DOS:_____ Immunization Administered:_____
☐ 90473 DOS:_____ Immunization Administered:_____

☐ *E/M NON-EPSDT*

☐ CPT: _____ Dx: _____ DOS:_____ ☐ CPT: _____ Dx: _____ DOS:_____

☐ *LABS* *CLIA CERTIFICATE NUMBER* _____

☐ CPT: _____ DOS:_____ ☐ CPT: _____ DOS:_____
☐ CPT: _____ DOS:_____ ☐ CPT: _____ DOS:_____
☐ CPT: _____ DOS:_____ ☐ CPT: _____ DOS:_____

☐ *OTHER*

☐ 17250 DOS:_____ ☐ 54160 DOS:_____ ☐ 96150 DOS:_____
☐ 51701 DOS:_____ ☐ 94640 DOS:_____ ☐ 96152 DOS:_____
☐ 54150 DOS:_____ ☐ 94760 DOS:_____ ☐ 97802 DOS:_____
☐ CPT: _____ DOS:_____ ☐ CPT: _____ DOS:_____

Practice Name:_____ Practice NPI:_____
Attending Physician (last name, first name): _____ NPI:_____
Contact Person:_____ Phone: _____ Fax: _____

Plan Point of Contact: _____ Date Plan Called: _____ Time of Call: _____
Plan Reference/Confirmation Number: _____

FOR MCO USE ONLY:

☐ Approved ☐ Denied Authorization # _____ Date of Notification to Pediatric Office: _____
Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

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