

Prior Authorization Request  
Nevada Medicaid and Nevada Check Up

**Automated Testing**  
(code 96146)

Upload this request through the Provider Web Portal.

Questions? Call: (800) 525-2395

<b>DATE OF REQUEST:</b> ____/____/____	
<b>Incomplete or illegible forms cannot be processed.</b>	
<b>RECIPIENT INFORMATION</b>	
Recipient Name (Last, First, MI):	
Recipient ID:	DOB:
Responsible Party Name:	
<b>REFERRING PROVIDER INFORMATION</b>	
Referring Provider Name:	NPI:
Phone:	Fax:
<b>PSYCHOLOGIST INFORMATION</b>	
Psychologist Name:	NPI:
Phone:	Fax:
<b>CLINICAL INFORMATION</b>	
Has previous testing been performed? <input type="checkbox"/> No <input type="checkbox"/> Yes: If yes, enter date and results: ____/____/____	
Results:	
Is this request for Healthy Kids (EPSDT) services? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Current symptoms and relevant history:	
Referral Question (specific reason for referral):	
<b>Requested Test</b>	
1.	
<b>Requesting Provider Signature:</b>	<b>Date:</b>

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*