

Outpatient Medical/Surgical

(Use Form FA-7 for Outpatient Rehabilitation and Therapy Services)

Upload this request through the Provider Web Portal. For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: ____/____/____

REQUEST TYPE: ☐ Initial ☐ Continued Services ☐ Retrospective* ☐ Unscheduled Revision

*REQUIRED FOR RETROSPECTIVE REVIEWS ONLY

This recipient was determined eligible for Medicaid benefits on: ____/____/____

NOTES:

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):

Recipient ID:

DOB:

Address:

Phone:

City:

State:

Zip Code:

Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:

Other Insurance Name:

Other Insurance ID#:

Responsible Party Name (if applicable):

Responsible Party Address:

Phone:

ORDERING PROVIDER INFORMATION

Ordering Provider Name:

NPI:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

SERVICING PROVIDER INFORMATION

Servicing Provider Name:

NPI:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

CLINICAL INFORMATION (attach additional sheets if necessary)

Code Requested	No. of Units Requested	Description of Service
1.		
2.		
3.		

Date of Request: _____

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