Prior Authorization Request
Nevada Medicaid and Nevada Check Up

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.		

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Recipient Name:_____ Date of Request:_____

4.		
5		

Is the service you are requesting a hospice benefit? ☐ Yes ☐ No

Are you requesting Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No

Conditions/Symptoms (include ICD-10 codes and descriptions):

Previous Treatment/Services *(include dates)*:

Results of Previous Treatment/Services:

Other Clinical Information *(to support medical necessity of the requested services)*: