## Prior Authorization Request Nevada Medicaid and Nevada Check Up

## **Ocular Services or Medical Nutrition Therapy Services**

Upload this reques	st through the F	Provider Web Por	rtal.								
For questions regarding this form, call: (800) 525-2395											
DATE OF REQUEST://											
<b>REQUEST TYPE:</b> 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 (L											
Recipient ID:					[	DOB:					
Address:					F	Phone:					
City: State:				Zip Code:							
Medicare Insurance Information: Part A Part B Medicare ID#:											
Other Insurance ID#:											
Responsible Party	Name (if appli	cable):									
Responsible Party Address: Phone:											
ORDERING PR	OVIDER INF	ORMATION									
Ordering Provider	Name:										
NPI:											
Address:											
City:			State	State: Zip Code:							
Phone: Fax:											
Contact Name:											
SERVICING PR		ORMATION									
Servicing Provider	Name:										
NPI:											
Address:			State								
City:					Zip Code:						
Phone:				Fax:							
Contact Name:		·		·· ·							
CLINICAL INFORMATION (attach additional sheets if necessary)											
Code Requested	No. of Units Requested	Description of Service		Sta	art Date	End Date					
1.											
2.											

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				-						
3.										
4.										
5										
Is the service you are requesting a hospice benefit?  Yes No										
Are you requesting Healthy Kids (EPSDT) referral/services? Yes No										
Allowed services without a prior authorization:										
<ul> <li>Ocular: One annual exam and refractive exam per recipient age 21 and older; recipients age 20 and under do not have limitations; medical necessity must be documented in the recipient's medical record.</li> </ul>										
• <b>Medical Nutrition Therapy:</b> Limitation of four hours for the first rolling year and two hours in subsequent rolling years, per recipient.										
Medical reason for services needed beyond the above stated guidelines:										
Results of previous treatment/services:										
Tresuits of previous										
Other clinical inform	mation (to supp	oort medical necess	ity of the requested s	ervices):						
	in not a minute - f	noumant. Doumant in a di	ngont upon elizibilite'' (	la hanafita, aantra-tu-lu-	limitations and states					
			ngent upon eligibility, availab efit program. The information							

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