

Non-Covered State Medicaid Plan Services Request Form for Recipients *under 21 Years Old*

This form is available on DMA's Web site at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Mail the completed, signed form to the Assistant Director of Clinical Policy and Programs, Division of Medical Assistance, 2501 Mail Service Center, Raleigh, N.C. 27699-2501 or fax it to (919) 715-7679. You may use additional sheets to supply any other information you think would be helpful. **Include evidence-based literature, if available.**

I. Recipient Information. This must be completed by a physician, licensed clinician, or other provider.

Name _____

Date of Birth ____ / ____ / ____ (mm/dd/yyyy) Medicaid Number _____

Address _____

II. Medical Necessity. All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name _____	Provider Name _____
Medicaid Provider # _____	Medicaid Provider # _____
Address _____	Address _____
Telephone _____	Telephone _____
Fax _____	Fax _____

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.) _____

What is the recipient's health history? (Include chronic illness.) _____

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.) _____

What treatment has been given for the diagnosis(es) above? [Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).] _____

On the next page, identify the requested procedure, product, or service (if applicable, please include CPT and HCPCS codes). Provide a description of how the requested item will correct or ameliorate the recipient's defect, physical or mental illness, or condition [the problem]. This description *must* include a detailed

