new mexico health connections

Prior Authorization (PA) Request Form

Fax completed form to: 1-866-446-3774
Phone number: 1-855-7MY-NMHC (769-6642), option 3
*** = Required Information**

Requestor's Contact Name: _____ Requestor's Contact Number: _____

PATIENT INFORMATION

*Name: _____ *Date of Birth: _____

*Member ID Number: _____ *Member Phone Number: _____

*Service Is: ☐ **Elective/Routine** ☐ **Expedited/Urgent**

Note: Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.

(For a claim denial or prior authorization denial, please submit an appeal through Customer Service at 1-855-769-6642.)

*REFERRAL SERVICE TYPE REQUESTED

Inpatient	Outpatient	Behavioral Health	Other
☐ Surgical Procedure	☐ Surgical Procedure	☐ Inpatient	☐ Skilled Device (SN/PT/OT/SP)
☐ Elective Admission	☐ PT, OT, ST	☐ Partial Hospitalization	☐ Durable Medical Equipment
☐ Elective Observation	☐ Imaging	☐ Intensive Outpatient	☐ Dental
☐ Skilled Nursing Facility	☐ Chiropractic	☐ Chemical Dependency	☐ Experimental/Investigational
☐ Rehabilitation	☐ Acupuncture	☐ Office Visits	☐ Transportation/Transfers
☐ Long-Term Acute Care	☐ Infusion Therapy		☐ _____

PROCEDURE INFORMATION

***ICD-10** Diagnosis: _____ Diagnosis Description: _____

***CPT/HCPCS** Code and Description *(Pricing is required for injections and durable medical equipment. Include unit of measure/frequency for supplies.)*: _____

_____

* Date(s) of Service: _____ * Number of Visits: _____

PROVIDER INFORMATION

Ordering Provider: ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Servicing Provider: ☐ *Same as Ordering*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Facility: ☐ *N/A*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ *Phone: _____

*Address: _____

Request for extension to authorization: _____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you are not the intended recipient, any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.