Prior Authorization (Non-Pharmacy) Request

MedStar Family Choice

Date: _________________________

MFC - Maryland Fax: (410) 933-2274

Member Name: (*Please print*) ___________________________________ **DOB:** ________________

Member MedStar ID #: ___________________________ **Medicaid ID #:** ___________________
(*MD ID begins with **91**…)*

Provider Name/Office: ______________________________ **NPI#** ___________________________

Provider Phone: ___________________________ **Provider Fax:** ___________________________

Contact Person Name: ____

Contact Phone w/ext: ____________________________ **Contact Fax:** ____________________
(If different from above)

MUST CHECK ONE: **Inpatient** ☐ **Outpatient** ☐

Date(s) of Service: ____

Facility Name: ____ **NPI#** ___________________

Diagnosis Code(s) /ICD-10: ____

CPT Code/HCPS: ____

____ **Units** __________

*****Please include all of the following documents that apply*****

- Clinical/Office Notes
- X-Rays/MRI/CT/PET Scan or other applicable radiology studies
- Lab results

☐ Approved ☐ Denied MFC Reviewer: _______________________________