GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE

PRIOR AUTHORIZATION REQUEST*

CHECK ONE:
☐ DME ☐ O&P ☐ CASE MGMT.

MAIL COMPLETED FORMS TO:
GMCF
P. O. Box 105329
Atlanta, Ga. 30348

1. Member Name (Last, First, M.I.)	2. Medicaid ID No.:	3. Nursing Home: ☐ Yes ☐ No

4. Birth Date:	5. Sex: ☐ Male ☐ Female	6. Address:	7. Telephone Number:

8. Prescribing Physician/Practitioner Name & Address:		11. Provider of Service(s) Name & Address:	
9. Provider License Number:	10. Telephone (AC / Number):	12. Medicaid Provider Number:	13. Telephone (AC / Number):

14. Requested Dates of Service: From: / / Thru: / /	15. Description of Service(s) Requested	
	16. Primary Diagnosis Requiring Service(s)	17. ICD 9-CM

18. Justification and Circumstances for Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

	19. Description of Procedures, Equipment or Other Services	20. Procedure Code	21. Requested or Estimated Price Per Unit	22. Months of Units of Service Requested	23. Units per Claim
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

24. Provider's Signature:→

25. Date Submitted:

Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of service.

This request is subject to Retrospective Peer Review.