NC DHB Request for Prior Approval – MPW

Recipient Information **DMA-0002 v1.0**

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (✓)
1			
2			
3			
4			
5			

Provider Information

6. Requesting Provider #:_____NPI: ☐ Atypical: ☐ 7. Taxonomy: _____

8. Address: _____ 9. Nine Digit Zip Code: _____

10. Billing Provider # (if different from requesting):_____NPI: ☐ Atypical: ☐ 11. Taxonomy: _____

12. Address: _____ 13. Nine Digit Zip Code: _____

14. Rendering Provider # (if different from billing):_____NPI: ☐ Atypical: ☐ 15. Taxonomy: _____

16. Address: _____ 17. Nine Digit Zip Code: _____

Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Requested Services Information

18. Check only ONE service:

a. ☐ Chiropractic b. ☐ Dental c. ☐ DME d. ☐ Home Health

e. ☐ Home Infusion Therapy f. ☐ Hospice g. ☐ Optical h. ☐ Personal Care Services

i. ☐ Podiatry j. ☐ Private Duty Nursing

19. Requested Begin Date: _____ 20. Requested End Date: _____

21. Reason the service is medically necessary for the pregnancy: _____

_____

_____

_____

_____

_____

Additional Information

(Include any additional information related to this request)

Requesting Provider's Signature:_____ _____ Date:_____