Prior Authorization (Non-Pharmacy) Request

MedStar Family Choice
DISTRICT OF COLUMBIA

Date: _____

MFC - District of Columbia Fax: (202) 243-6258

Enrollee Name: (*Please print*) _____**DOB:** _____

Enrollee MedStar ID #: _____ **Medicaid ID #:** _____
(*ID begins with **61**…)*

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: _____