Idaho Medicaid Medical Prior Authorization Form
Fax to: 1 (877) 314-8779

Authorization Request & Required Contact Information

☐ *Surgery ☒ ♦Lab ☐ *Procedure ☐ Chiropractic ☐ Home Health

Submitter Contact Name: Email: Phone:

Date faxed to Medicaid: Proposed Date(s) of Service:

Medicaid Provider Information

Provider Name: NPI:

City: Phone: Fax:

***For surgery & procedure requests ONLY- Complete section below:**

Name of facility: NPI:

♦For lab requests ONLY- Complete section below:

Name of billing hospital or lab: **Idaho Cytogenetics Diagnostic Laboratory** NPI: **1891811931**

Medicaid Participant Information

Last Name: First Name: Initial:

Date of Birth: Medicaid ID Number:

CPT Code(s) Requiring Authorization & Supporting Documentation

CPT (include quantity or modifier): 81229

Description: Diagnostic SNP chromosomal microarray testing

Please fax all medical documentation that supports medical necessity. For example, physician notes, surgery reports and/or medical records within the last six months.

Provider Notes:

For questions regarding authorization number, requirements, limitation or status, call Molina Customer Service at 1 (866) 686-4272 or see the Molina HealthPAS portal at www.idmedicaid.com.

See www.medunit.dhw.idaho.gov, Surgery-Procedure-Lab for the Medicaid Fee Schedule link or additional information.