STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE//PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE?
YES ☐ NO ☐

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐M ☐F	4. DATE OF BIRTH (MMDDYY)

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER
	( )

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY)	THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐YES ☐NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME

11. ICD-10-CM DIAGNOSIS CODE **and** DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)	12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED
	13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?
	14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME	22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)

TELEPHONE NUMBER ( )	23. PCP PROVIDER NUMBER

24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION	25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE

26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED

TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER ( )	29. BILLING PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

*** THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT**