



Request for Medicaid Coverage of Medically Necessary Special Services for a Child Under Age 21 (Optional)

Patient Name: _____ Date of Birth: _____ Medicaid ID: _____

This section must be completed by a physician, licensed clinician, or other provider

Requesting Provider Name: _____ National Provider ID _____ Telephone: _____ Fax: _____

Rendering Provider Name: _____ National Provider ID _____ Telephone: _____ Fax: _____

Provider Type/Specialty: _____ This request is for a: Product _____ Procedure _____ Service _____

CPT/HCPCS Code, (if none, please describe): _____ Expected Frequency/Duration of Treatment: _____

Is the request experimental or investigational? Yes No
(If yes, provide name and protocol) _____

Is the request considered to be safe? Yes No
(If no, please explain why necessary) _____

Is the request proven effective? Yes No
(If no, please explain why necessary) _____

Is the request furnished in a manner primarily intended for the convenience of the provider, child, or parent/caregiver? Yes No
(If no, please explain why necessary) _____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the patient's defect, physical or mental illness, or condition.
(If more space is needed, please attach additional comments) _____

Requestor's Signature and Credentials: _____ License#: _____ Date: _____

Please attach all related medical records and evidence-based literature

For instructions on how to complete this form go to: ahca.myflorida.com/CHCUP



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This section must be completed by Medicaid Area Office

Submitting Area Office: _____	Name: _____	Telephone: _____	Fax: _____
Signature: _____		Date: _____	

This section must be completed by the Medical Consultant

Comments:	Approved: _____	Denied: _____	Duration: _____
_____ _____ _____ _____			
Signature: _____		Date: _____	

This section must be completed by AHCA Headquarters

Program Assigned: _____	Name/Title: _____	Date: _____
CPT/HCPCS Code: _____	Provider Type: _____	Duration: _____
Comments:		
_____ _____ _____ _____		