



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

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: _____ _____ _____ _____		