**HUSKY Health Program Doula Services**
**Prior Authorization Request Form**
**Phone: 1.800.440.5071**

**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

| **Member Information** | | | |
|---|---|---|---|
| Member ID Number: | Member Name (Last, First): | | |
| Address: | City, State, Zip: | | |
| DOB: | Age: | Primary Diagnosis: | Primary Diagnosis Code: |

| **Billing Provider Information** | |
|---|---|
| Medicaid Billing Number: | Billing Provider Name: |
| Street Address: | City, State, Zip: |
| Contact Name: | Contact Telephone Number: |
| Contact Fax Number: | |

| **Ordering Provider Information** | |
|---|---|
| Medicaid Billing Number: | Ordering Provider Name: |
| Street Address: | City, State, Zip: |
| Contact Name: | Contact Telephone Number: |
| Contact Fax Number: | |

**Authorization Information**

**Note: Prior authorization is not needed for one attendance at labor and delivery doula visit and the first four antepartum/postpartum doula visits. Prior authorization is required for additional visits.**

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| Start Date of Service: | End Date of Service: |
| HCPCS Code: | Number of Visits Requested: |

1. How many doula visits has the member had? _____

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|---|---|---|---|---|
| 2. Has the member delivered? | □ Yes<br>Delivery Date: | | □ No<br>EDD: | |
| 3. When will the requested visits occur? | | □ Prenatal | □ Postpartum | □ Both |
| 4. Are the additional doula visits ordered by a *CMAP-enrolled physician, APRN, CNM, or PA who is assuming responsibility for the pregnancy and postpartum period?<br>**Connecticut Medical Assistance Program* | | | ◯ Yes | ◯ No |
| 5. Name of physician, APRN, CNM, or PA ordering/referring for services:<br>_____ | | | Credentials: | |
| 6. Will the services be provided by a doula enrolled in CMAP and certified by the Connecticut Department of Public Health (DPH)? | | | ◯ Yes | ◯ No |

7. Name of doula who will be providing services:
_____

8. What is the condition or clinical scenario that may benefit from additional doula visits? ***Please explain.***

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| 9. What is the purpose of additional visits (e.g., non-medical support, provision of evidence-based educational materials, etc.)? ***Please describe.*** |
| **Certification Statement:** This is to certify that the requested service is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability. |

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| Provider Signature: | Date: |