HUSKY Health Program Medical Nutrition Therapy
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 the first three hours of Medical Nutrition Therapy (MNT) per calendar year.

1. Are the services ordered by a *CMAP-enrolled physician, APRN, CNM, or PA? **Connecticut Medical Assistance Program*	○ Yes	○ No
2. Name of physician, APRN, CNM, or PA ordering/referring for services: _____	Credentials:	
3. Will the services be provided by a CMAP-enrolled dietitian-nutritionist certified by the Connecticut Department of Public Health (DPH)?	○ Yes	○ No
4. Name of certified dietitian-nutritionist that will be providing services: _____		

CPT Code and Units Requested

Please select the CPT code(s) for which you are seeking authorization. Please review the CPT code description to determine the appropriate number of units. Units are in increments of 15-minute or 30-minute blocks. Up to 3 additional hours per calendar year may be authorized.

☐ CPT Code 97803	Units:	☐ CPT Code 97804	Units:
Start Date of Service:		End Date of Service:	

Clinical Information

1. Please select the clinical scenario that supports the medical necessity of the requested services:
   - ○ The individual is experiencing an exacerbation or worsening of symptoms related to their diagnosis. ***Please describe***:

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- The individual has had a recent hospitalization or readmission (since initiation of MNT) related to their nutritional status. ***Please provide dates of hospitalization***: _____
- The individual has a cognitive disorder that delays processing of information related to their diagnosis and/or nutritional intake. ***Please provide diagnosis***: _____

2. Is there a documented plan of care listing problems, measurable goals, and interventions? ***Please attach plan of care.***	○ Yes	○ No
3. Do treatment notes indicate the interventions performed with progress toward goals? ***Please attach all treatment notes.***	○ Yes	○ No

4. Please explain why an additional three hours of MNT are needed.

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.

Provider Signature:	Date: