Children's Mercy
PEDIATRIC CARE NETWORK

PRIOR AUTHORIZATION FORM

INSTRUCTIONS: Please call or fax the following information to Pediatric Care Network. PCN will verify benefits, eligibility, and provider network status and make you aware of non-covered services. Within 36 hours PCN will call you with a determination. Authorization numbers issued for covered services should be included on claims submitted.

Payment is subject to eligibility status and benefits that are in effect at the time services are provided. PCN will not assume financial responsibility for services where prior notification does not occur according to PCN policies. You must notify PCN if additional services or an extension is required.

PLEASE CHECK ONE: ☐ **Routine** **Prior Authorization #**_____ **(if applicable)**

☐ **Urgent** *(The member's life, health or safety could be jeopardized or adverse health consequences could occur without the requested service.)*

Date Form Completed	Member Name
Member ID # & DOB	Service Start Date/Requested Visits/Treatment Duration
Requesting Physician/Practitioner	Provider of Services (Please include NPI and Tax ID#)
Diagnosis/Treatment	Admission Facility (if appropriate)

Please complete the information below and attach any necessary supporting clinical documentation needed for service consideration. Please include the specific service and number of visits, if applicable.
Please refer to your PCN Provider Quick Guide or the PCN Website. (www.cmics.org/pcn)

Service or Item Requested:_____

Length of Need or # of Visits/Items:_____

CPT/HCPCS **Code(s)**:_____

DME-**Include Code** and Description of item(s):_____

Request: NEW_____EXTENSION_____

Physician's Order (Attach Copy):_____

Medical Necessity Documentation (Attach Documentation):_____

Home Health – Copy of Order and Plan of Care:_____

Contact Name (please print):_____

Contact Telephone:_____ Fax: _____

Toll Free MO PCN Phone: 877-347-9367 **Toll Free Fax: 888-670-7260**

Toll Free KS PCN Phone: 833-802-6427