

Authorization Request		Purchase of Medical Care Services DHHS—Division of Public Health 1904 Mail Service Center Raleigh, NC 27699-1904		FOR POMCS USE ONLY	
1. Last Name		First Name		MI	
2. Patient SS#		3. Date of Birth (M/D/YYYY)		4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
5. Race <input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black <input type="checkbox"/> 3. American Indian <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 6. Multi-racial		6. Ethnicity: Hispanic or Latino Origin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		7. Preferred Language Select from the list on the back of this form.	
8. Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No Local Jail (Name) Federal Halfway House (Name)		9. County of Residence		County Code	
10. Address (Street or RFD)		11. City		State	
12. Telephone # (Home)		13. Telephone # (Work)		14. Authorization Number	
13. Alternate Contact Last		First		Middle	
18. Diagnostic Code/Diagnosis: Primary <b>042</b>		Secondary		15. POMCS Case Number	
19. COMPLETE FOR ALL HIV REQUESTS A. CD <sub>4</sub> Count Date (M/D/YYYY) B. Viral Load Date (M/D/YYYY)		20: Medications will be shipped to patients address unless indicated otherwise below. If applicant is incarcerated, see instructions on back of form: Care of, if applicable: Street Address: State Rd/RFD: City: State/Zip Code:		16. Provider of Requested Service  <b>CVS CAREMARK 1-800-238-7828</b>	
21. FOR ALL HIV REQUESTS Clinician's Information: Phone #: Fax #: NC License #:		22. Requesting Office Agency: Contact: Address: Phone #: Date: (M/D/YYYY)		17. Requested dates of service	
23A. Type or print Clinician's name		23B. Clinician's Signature (I certify that the above named individual has prescriptions for medications listed on the current NC TIER 1 ADAP Formulary)			

# INSTRUCTIONS

## PURPOSE

This form is used to request authorization for reimbursement from the ADAP program.

Processing time is reduced when this form is legible and complete. If requested, additional information must be received within one year after the date of service or within 30 days of notification, whichever is later. Incomplete forms will be returned.

**Authorization Requests should be submitted without documentation if necessary to meet deadlines.** Requests will not be processed until all information is received.

## INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM

7. Select one of the languages in the box (below right) and enter the 2 letter corresponding code in block "7" on the front of this form.
8. If applicant/patient is incarcerated, check the box and indicate where applicant is currently residing. **NOTE: Patients who are incarcerated in a state or federal prison cannot participate in the ADAP Program.**
- 14., 15. For POMCS use only. Do not complete these items.
17. Will be the authorization date unless another date is requested and specified in this box.
18. If applicable, enter secondary diagnosis code.
20. If patient/applicant is incarcerated in local jail, please provide alternate shipping address (friend, relative). Medications cannot be shipped to facility. If patient/applicant is incarcerated in federal halfway house, medications will be shipped to address listed in block #10.
21. Enter clinician's telephone number, fax number and NC License number.

(AR) Arabic	(HM) Hmong	(PO) Polish
(CA) Cambodian	(HU) Hungarian	(PG) Portuguese
(CH) Chinese	(IT) Italian	(PC) PG Creole
(EN) English	(JA) Japanese	(RU) Russian
(FR) French	(KO) Korean	(SC) Serbo-Croatian
(FC) French Creole	(LA) Laotian	(SP) Spanish
(GE) German	(MI) Miao	(TA) Tagalong
(GR) Greek	(MK) Mon-Khmer	(TH) Thai
(GU) Gujarati	(OT) Other	(UR) Urdu
(HI) Hindi	(PE) Persian	(VI) Vietnamese

**FAX or MAIL REQUESTS TO:** Purchase of Medical Care Services  
 (do not do both) DHHS-Division of Public Health  
 1904 Mail Service Center  
 Raleigh, NC 27699-1904  
 (919) 715-5221 (FAX)

**Faxed Authorization Requests are not given priority.** Requesting offices should contact POMCS regarding the need to expedite a request.

**WEBSITE:** [www.ncdohhs.gov/control/pomcs/pomcs.htm](http://www.ncdohhs.gov/control/pomcs/pomcs.htm)

**ADAP WEBSITE:** [www.epi.state.nc.us/epi/hiv/adap.html](http://www.epi.state.nc.us/epi/hiv/adap.html)