Non-Covered State Medicaid Plan Services Request Form for Recipients *under* 21 Years Old

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:
http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html

This form may be found at [http://www.nctracks.gov](http://www.nctracks.gov)

This form MUST accompany your Prior Approval request for EPSDT consideration via submission through provider portal, fax or mail. **DO NOT** send this form to CSC without an accompanying Prior Approval request. It will not be processed without a Prior Approval Request.

Upload the completed form to the Prior Approval request in NCTracks, fax it to 855-710-1964 or mail it to CSC PO Box 31188, Raleigh, NC 27622-8009. You may use additional sheets to supply any other information you think would be helpful. Include evidence-based literature, if available.

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**I. Recipient Information:** This must be completed by a physician, licensed clinician, or other provider.

Name: ____________________________________________________________

Date of Birth: ____/____/_____ (mm/dd/yyyy)  Medicaid ID Number: __________________

Address:

______________________________________________________________

______________________________________________________________

______________________________________________________________

**II. Medical Necessity:** All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: __________________________  Provider Name: __________________________

NPI: __________________________  NPI: __________________________

Address: __________________________  Address: __________________________

Telephone: (____)____-______  Telephone: (____)____-______

Fax: (____)____-______  Fax: (____)____-______

Requested procedure, product or service: __________________________  CPT/HCPCS code: ____________/__________

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the
nature of the care.)
What is the recipient’s health history? (Include chronic illness.)

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient’s current status.)

What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals, and the recipient’s response to treatment(s.).)

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient’s defect, physical or mental illness, or condition (the problem.) This description must include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment? _______ Yes _______ No
If yes, provide name and protocol number: ________________________________

Is the requested product, service, or procedure considered to be safe? _______ Yes _______ No
If no, please explain. ________________________________________________________

Is the requested product, service or procedure effective? _______ Yes _______ No
If no, please explain. ________________________________________________________
Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? Yes _______ No _______
If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available.

What is the expected duration of treatment?

Requestor’s Signature & Credentials ___________________________ Date ___________________________