One request per form. Separate approvals must be obtained for the facility and the provider.

PED-I-CARE MEDICAL AUTHORIZATION REQUEST FORM

Fax requests to (866) 256-2015 • For questions call (800) 492-9634

eINFOsource Provider Portal: https://cms.einfosource.med3000.com

Ped-I-Care website: http://pedicare.pediatrics.med.ufl.edu/

Florida HEALTH CMS Managed Care Plan

UF Ped-I-Care Department of Pediatrics UNIVERSITY of FLORIDA

Program: ☐ **Title 19 MMA-CMS Plan** ☐ **Title T21**

Request Type: ☑ **Standard** ☐ **STAT*** ☐ **Retro** (service already provided) ☐ **ER or Observation Stay Notification**

**Standard timeframe could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function.*

Member: _____ DOB: _____ Member ID#: _____ Age: _____ Gender: ____

	Requesting Provider	Requested Provider/Facility	PCP (If not already listed)
Provider Name		Invitae Corporation	
Specialty		Genetic Testing	
Tax ID #		271701898	
Contact Name		Patrick Hamm	
Phone #		415-374-7782 ext 503	
Fax #		510-417-3922	

Diagnosis Code(s):_____ **CPT/HCPCS Code(s), if applicable:** _____

AUTHORIZATION INFORMATION – Requests require the submission of supporting clinical documentation.

Provider/Facility is: ☑ Participating ☐ Non-Participating (Include address, contact info, NPI #, and for T19 the Medicaid #)

Date of Admit/Service: _____ ☑ Elective (Includes scheduled) ** ☐ Emergent (in 24 hours)

Requested Dates: _____ through _____ **Total:** _____ ☐ Days ☐ Weeks ☐ Months

Procedure: _____

☐ Inpatient Surgery/Services ☐ Outpatient Surgery/Services ** ☐ Transplantation & Related Care

☐ Experimental/Investigational Treatment ☐ Out-of Network Request for: _____

☐ Other _____

Items/Supplies **

☐ Augmentative Communication System/Device

☐ DME:_____

☐ Orthotics/Prosthetics:_____

Hearing: ☐ Hearing Aids ☐ Cochlear Implant

Nutritional Supplements: (Include forms and order)

☐ Enteral ☐ TPN

Vision: ☐ Contact Lenses ☐ Specialty Glasses

Services/Procedures +

☐ Diagnostic Imaging of: _____

☐ MRI ☐ MRA ☐ CT Scan ☐ PET Scan

☑ Genetic Testing *** (Include Supplemental Form)

☐ Oral Surgery **

☐ Orthodontia ** (Include Medicaid score sheet and films and/or photos if score doesn't meet guidelines)

Days/Week: _____ **Units/Day:** _____ **Total Units:** _____

Choose one service type and include a signed plan of care.

Home Health Services ☐ Home Health Aide

PDN: ☐ LPN ☐ RN ☐ Home Infusion

Is another child in the home already receiving home health services? ☐ Yes ☐ No

Therapy ☐ Physical ☐ Occupational ☐ Speech ☐ Respiratory

Applied Behavioral Analysis (ABA) Therapy

T21 – Fax to Concordia: (305) 514-5321 or (855)698-7790

Questions: (877) 698-7789 option 2, option 1

T19 - *Request through the Local Medicaid Area Office*

Prescribed Pediatric Extended Care (PPEC)

T21 - # Full Days: _____ # Half Days: _____

T19 - *Request through eQHealth @ 1-855-444-3747*

Transportation (For routine, non-emergent transportation to medical appointments)

T21 - *Call TMS @ 1-855-739-5986 to request services* **T19 -** *Call TMS @ 1-866-411-8920 to request services*

**** For services that have a by report (BR) or prior authorization (PA) indicator on the Medicaid Fee Schedule.**

***** If not on Medicaid fee schedule, or if genetic testing is with an out-of-network provider.**

+ MRIs and CTs do not require PA if the diagnosis code is listed in Appendix D of the Practitioner Services Coverage and Limitations Handbook. For diagnoses not listed, PA is required.

Updated: 8/5/2016

UF Ped-I-Care
Department of Pediatrics
UNIVERSITY of FLORIDA

Florida HEALTH
CMS Managed Care Plan

PED-I-CARE GENETIC TEST REQUEST SUPPLEMENTAL INFORMATION

Please complete this form and submit along with the Ped-I-Care Medical Authorization Request Form, CMS Special Exemption Form, and supporting clinical documentation. This information will be reviewed by the Medical Director.

Member: _____ **DOB:** _____ **Age:** _____ **Gender:** _____

Requested Test:

Test description (including documentation):

Specificity of test: Sensitivity of test:

Laboratory: Invitae Corporation Laboratory Phone #: 415-374-7782

Address: 1400 16th Street, San Francisco CA 94103

Major clinical features:

Previous pertinent lab studies/diagnostic investigations:

Level of actionable consequences of testing (please answer all that are applicable):

Genetic Counseling for future children in family:

Medical monitoring changes:

Treatment considerations:

Life altering changes: