Request for Extension of Administrative Authorization of Services due to Fair Hearing

Fax – 1- 855-677-3747

Request Date: _____

RECIPIENT INFORMATION

Recipient Name: Last, First, Middle

_____

Date of Birth: ☐☐/☐☐/☐☐

Medicaid ID #: ☐☐☐☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

REQUESTOR AND PROVIDER INFORMATION

Requestor's Name: _____

Requested by: ☐ Facility ☐ Physician ☐ Recipient/Representative

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

email: _____

Hospital, Home Health Services, or PT, OT, ST Provider Name:

_____

Provider's Medicaid ID #: ☐☐☐☐☐☐☐☐☐☐

TYPE OF SERVICE

Indicate the service the Recipient is to/was receiving:

- ☐ Home health visits
- ☐ Private duty Nursing/Personal Care Services
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech-language Pathology

REQUEST FOR EXTENSION OF ADMINISTRATIVE AUTHORIZATION OF SERVICES DUE TO FAIR HEARING

Review ID #: ☐☐☐☐☐☐☐☐☐

eQHealth Case ID#: ☐☐☐☐☐☐

KePRO Case ID#: ☐☐☐☐☐☐☐☐

Date of Admission/Start of Service: ☐☐/☐☐/☐☐

Date of Discharge, if applicable: ☐☐/☐☐/☐☐

Please extend the administratively authorized services for the above identified recipient. I acknowledge that this request is valid through the current certification period. At the end of the certification period, if the final order is not rendered, I will submit a request for another extension. When the Fair Hearing Officer issues the final written order for the identified recipient, the authorization will be modified as ordered. I understand it is my responsibility to maintain all required documentation to submit for a continued stay review.

Signature of Requestor / Provider **Print Name of Requestor / Provider**