CONTROL NUMBER * FOR ACS USE ONLY

AFFIX LABEL HERE

AFFIX LABEL HERE

Affiliated Computer Services, Inc.

STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DO NOT USE THIS FORM TO REQUEST LONG TERM CARE PLACEMENT

PRIOR AUTHORIZATION REQUEST

SEQUENCE NUMBER
P

(PLEASE TYPE) FOR HEALTH CARE PROFESSIONAL (HCP) USE

1. HCP PHONE NO. ( )
2. HCP IDENTIFICATION NO.
3. REQUEST IS RETROACTIVE? ☐ YES ☐ NO
4. HCP NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

5. RECIPIENT NAME (LAST, FIRST, MI)
6. RECIPIENT ID NO.
7. STREET ADDRESS
8. SEX
9. DATE OF BIRTH
10. AGE
11. CITY, STATE, ZIP CODE
12. PHONE NUMBER ( )
13. DIAGNOSIS AND MEDICAL JUSTIFICATION:
14. PRIMARY ICD-9-CM DIAGNOSIS CODE

FOR ACS USE

20. HCP: YOUR REQUEST IS:

☐ APPROVED AS REQUESTED

☐ APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)

PRIOR AUTHORIZATION NUMBER
FROM DATE MM/DD/YY TO DATE MM/DD/YY

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

☐ DENIED

BY ______
AUTHORIZING AGENT

21. AGENT NUMBER
22. DATE MM/DD/YY
23. COMMENTS / EXPLANATION

	15. PROCEDURE/ DRUG CODE	MOD.	16. SPECIFIC SERVICES REQUESTED	17. REQUESTED UNIT / QTY	18. CHARGES	AUTHORIZED 24. YES	AUTHORIZED 25. NO	26. APPROVED UNIT / QTY	27. APPROVED AMOUNT
1									
2									
3									
4									
5									
6									

19. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR HEALTH CARE PROFESSIONAL ______ TITLE ______ DATE ______

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY.
BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

SEND WITH PART TWO

FORWARD THIS FORM TO: ACS, P.O. BOX 240808, ANCHORAGE, ALASKA 99524-0808

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AK-PA (11/08)