

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

This form is available on DMA's Web site at:  
<http://www.ncdhhs.gov/dma/provider/forms.htm>.

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](http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html)

Mail the completed, signed form to the Assistant Director of Clinical Policy and Programs, Division of Medical Assistance, 2501 Mail Service Center, Raleigh, N.C. 27699-2501 or fax it to (919) 715-7679. You may use additional sheets to supply any other information you think would be helpful. **Include evidence-based literature, if available.**

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

**Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) **Medicaid 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** \_\_\_\_\_  
**Medicaid Provider #** \_\_\_\_\_ **Medicaid Provider #** \_\_\_\_\_  
**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. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_ MID \_\_\_\_\_ DOB \_\_\_\_\_

**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 # \_\_\_\_\_  
\_\_\_\_\_

**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**