**NorthCare Network Children’s Waiver Program
Prior Review and Approval Request Form**

**Medicaid ID:**

**Date of Request:**

**DOB:**  MCOID:

**Child Name:**

**County:**

**CMHSP:**

**CM Telephone Number:**

**Case Manager:**

**Address:**

**MCOID:**  MCOID:

|  |  |  |
| --- | --- | --- |
| **Description of Services (include brand name, model etc.)** | **Quantity**  | **Dollar Amount** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**THE FOLLOWING ITEMS ARE REQUIRED FOR A COMPLETED PRAR REQUEST PACKET:**

Original Physician Order: Y N Narrative Justification of Need by Appropriate Professional: Y N Three Big Request: Y N

Copy of Habilitation Program Related to This Request: Y N Denial of other payment source: Y N

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Case Manager/Supports Coordinator Signature Date

**NorthCare Network Use Only**

Enrolled Waiver Participant: Y N Enrollment Current (all required recertification documents up to date): Y N

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Clinical Review team Chair or Designee Date**

**Denied**

**No Action taken**

**Approved as:**

**Presented**

**Amended**