

ODHS 3142 Prior Authorization Form

ODHS 3142 (Rev. 9/98)

PRIOR AUTHORIZATION
Type or Print Legibly

State Use Only

Prior Authorization Control Number

Check type of Medical Card: ☐ Medicaid ☐ Disability Assistance (DA) ☐ GMB ☐ Other _____

The Provider is responsible for verifying client eligibility at the date of service by viewing the client's Medical Card

Provider Information

Provider Number	Date Form Completed
Provider Name	
Street Address	
City, State and Zip Code	
Provider Telephone Number and Ext. ()	Provider Fax Number ()
Contact Person	

Client Information

Billing Number	Client's Last Name		First Name
Street Address/Facility Name and Address			
City and Zip Code		County	
Client Resides: ☐ LTC Facility ☐ MRDD Facility		Date of Birth	
☐ Personal Residence		/ /	
☐ Other, specify _____			

Attach Prescription/Certification signed by the appropriate physician or practitioner including the complete diagnosis medical history, degree of impairment, and medical necessity. Give complete description of service or item (including make, model, serial number, freight charges and NDC code.) Attach any additional supportive information.

REQUESTED SERVICES

	Quantity	Procedure Code	Usual and Customary Charge
1.			
2.			
3.			
4.			
5.			
6.			

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

Notes:

SERVICE/RENTAL DATES

☐ No Previous Service

Previous Service/Rental Dates (inclusive)

FROM:

TO:

This Request-Service/Rental Dates

FROM:

TO:

Dispense Date

STATE USE ONLY - DO NOT COMPLETE SECTIONS BELOW

	Quantity	Code	Approved Dollar Amount	Approve	Deny	Reason Code	Override Code
1.							
2.							
3.							
4.							
5.							
6.							

Line No.

Comments

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Reviewer

Date

Submit to Ohio Department of Human Services, Medical Operations Section P.O. Box 1002, Columbus, Ohio 43268-0002. Do not send claim with this form. Approved prior authorization is contingent upon eligibility of client at the time of service and the department's claim and prior authorization filing limitations. Completion of this form is required by rule 5101:3-1-31 of the Ohio Administrative Code for provider to be eligible for reimbursement of Medicaid Services requiring prior authorization.