Hearit LLC
8346 N. Mammoth Dr.
Tucson, AZ 85743
Tel: 1-800-298-7184
Fax: 520-579-3368

THSteps – CCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned

Request for DME Supplies Private Duty Nursing Inpatient Rehabilitation Other

_____ _____ _____
Client Name (Last, First, MI) Medicaid Number (PCN) Date of Birth

_____ _____ _____
Name of Supplier/Vendor Medicaid Provider Number Phone Number

_____ Phone _____

_____ Fax _____
Address of Supplier/Vendor

Diagnosis and Medical Necessity of requested services: _____

_____

Date of Service From _____ To _____

HCPCS Code	Brief description of Requested Services	Retail Price
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: HCPCS codes and description must be provided.

By prescribing the identified DME and/or medical supplies, I certify to the following:

The client is under 21 AND
The prescribed items are appropriate and can safely be used by the client when used as prescribed

_____ _____
Signature of prescribing prescription Date

For NHIC Use Only

_____
Printed or typed name of physician

Mail completed form to: Hearit LLC • 8346 N. Mammoth Dr. • Tucson Arizona 85743 or Fax 520-579-3368