

Prior Authorization Request  
Nevada Medicaid and Nevada Check Up

## Ocular Services or Medical Nutrition Therapy Services

Upload this request through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

**DATE OF REQUEST:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**REQUEST TYPE:** ☐ Initial ☐ Continued Services ☐ Retrospective\* ☐ Unscheduled Revision

**\*REQUIRED FOR RETROSPECTIVE REVIEWS ONLY**

This recipient was determined eligible for Medicaid benefits on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NOTES:**

**RECIPIENT INFORMATION**

Recipient Name (Last, First, MI):

Recipient ID:

DOB:

Address:

Phone:

City:

State:

Zip Code:

Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:

Other Insurance Name:

Other Insurance ID#:

Responsible Party Name (if applicable):

Responsible Party Address:

Phone:

**ORDERING PROVIDER INFORMATION**

Ordering Provider Name:

NPI:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

**SERVICING PROVIDER INFORMATION**

Servicing Provider Name:

NPI:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

**CLINICAL INFORMATION** (attach additional sheets if necessary)

Code Requested	No. of Units Requested	Description of Service	Start Date	End Date
1.				
2.				
3.				

Prior Authorization Request  
Nevada Medicaid and Nevada Check Up

**Ocular Services or Medical Nutrition Therapy Services**

Recipient Name: \_\_\_\_\_

Date of Request: \_\_\_\_\_

4.				
5.				

Is the service you are requesting a hospice benefit? ☐ Yes ☐ No

Are you requesting Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No

**Allowed services without a prior authorization:**

- **Ocular:** One annual exam and refractive exam per recipient age 21 and older; recipients age 20 and under do not have limitations; medical necessity must be documented in the recipient's medical record.
- **Medical Nutrition Therapy:** Limitation of four hours for the first rolling year and two hours in subsequent rolling years, per recipient.

Medical reason for services needed beyond the above stated guidelines:

--

Results of previous treatment/services:

--

Other clinical information (to support medical necessity of the requested services):

--

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*