

## Prior Authorization Data Correction Form

**Purpose:** Use this form to correct or modify non-clinical, administrative data on a previously submitted prior authorization request. This form cannot be used to request re-determination of medical necessity, nor does it take the place of a prior authorization request. Please allow up to 30 days for processing.

**Attachments:** Attachments are not required with this form. Documentation to fully support medical necessity must be submitted with the prior authorization request and be available in the recipient's medical record.

**Upload this form through the Provider Web Portal.**

**Questions:** If you have any questions, please call Nevada Medicaid at (800) 525-2395.

<b>NOTES:</b>	
Submission Date of This Form:	Date(s) of Service:
Are you an out of state provider? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does TPL exist? <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>SERVICE TYPE</b> <i>Indicate the type of service for which you are requesting a data correction.</i>	
<input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Inpatient Medical/Surgical <input type="checkbox"/> Inpatient LTAC <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Outpatient Medical/Surgical <input type="checkbox"/> Outpatient Rehab <input type="checkbox"/> Outpatient Therapy <input type="checkbox"/> PCS <input type="checkbox"/> RTC	
<b>AUTHORIZATION NUMBER</b>	
11-digit Authorization Number assigned to your original request:	
<b>BILLING PROVIDER INFORMATION</b>	
Provider Name:	NPI:
Contact Name:	
Phone:	Fax:
<b>INFORMATION TO MODIFY</b>	
What non-clinical data on your original request should be modified?	
Why should this data be modified?	
<b>RECIPIENT INFORMATION</b>	
Recipient Name:	
Date of Birth:	Recipient ID:
Admission Date or Begin Date of Service:	Discharge Date: