

MEDICAL DAY CARE REQUEST FORM

As of Oct. 1, 2015,
ICD-10 codes are
required.

Fax Completed Form to: 1-609-583-3048

Adult Request

Pediatric Request

Please check type of request:

Initial Request Re-Assessment Facility Transfer HMO Transfer Change Request

Date Submitted to HNJH:

Please provide the following member demographic information:

Member County: # _____

Member Name: _____ HNJH Mbr ID# _____ DOB: _____

Member Address (Street/City) _____

Member Phone # _____ Translation Needed: Yes / No If yes language: _____

Please provide the following information:

Current Authorization Expires on: _____ Requesting # days per week: _____

Has member had a lapse in service for 30 consecutive days during the prior authorization period? Yes / No

(ICD-10 codes are required for all requests and claims)

Primary Dx: _____ ICD-10 _____ Other Chronic Dx _____ ICD-10 _____

Other Chronic Dx: _____ ICD-10 _____ Other Chronic Dx: _____ ICD-10 _____

Please check one of the following codes:

____ Ped Med Day (technologically dependent) T1024 w/modifier 22

____ Adult Med Day S5102

____ Ped Med Day (medically fragile) T1024 w/ modifier 52

Change in Service Request (Please circle): Increase / Decrease

Information to support service request change (must provide specifics): _____

REQUIRED ADDITIONAL INFORMATION:

Medical Day Care Provider Name: _____ Provider ID# _____

Medical Day Care Contact : _____ Phone # _____

Address of Facility where member attends: _____

Phone # of Facility _____ Fax # of Facility _____