Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care

Prior Authorization Request: Radiology

Service Information:

MemberName:_____

Member ID:_____

Date of Birth:_____

Diagnosis (Diagnosis Code with description):_____

Start date:_____ **End date:**_____

Treating Physician (Physician name and NPI):_____

Street address:_____ **, City:**_____**State:**_____**Zip Code**_____

Treating Facility(Medicaid Provider ID #):_____

Street address:_____ **, City:**_____**State:**_____**Zip Code**_____

Does the Member live:

- ☐ **Alone at home**
- ☐ **At home with assistance**
- ☐ **Nursing facility or ICF/DD**
- ☐ **Other**

Services to Be Authorized:

HCPC Code	Modifier	LT/RT	Units of Service	Unit Price	Description of Service

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Nurse Review:

Comments:_____

_____

_____

☐Approved ☐Refer to Peer Reviewer

Peer Review:

Review Finding:

Review Rationale

☐Approved ☐Denied ☐Reconsideration Upheld ☐Reconsideration Overturned

Physician Reviewer Name:_____