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

Prior Authorization Request: Ultraviolet cabinet

Service Information:

Member Name:_____

Member ID:_____

Date of Birth:_____

Diagnosis (Diagnosis Code with description):_____

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

Treating Physician (Physician name andNPI):_____

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

Specialty Provider(Provider name andNPI):_____

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	Units of Service	Unit Price	Description of Service

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Rental Period Requested: From date: _____ Thru date: _____

Rental Items Only:

Purchase Price	Date Delivered	New	Used

Please Complete All of the Following Questions:

1. Does Member have generalized, intractable psoriasis, supported by submitted documentation?

- ☐ Yes
- ☐ No

2. Does the Member have medical conditions that prevent the client from obtaining ultraviolet treatment in an outpatient setting? If yes, supporting documentation required.

- ☐ Yes
- ☐ No

3. Is there a written physician order?

- ☐ Yes

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☐ No