Vaya Health

Non-Covered Services Request Form for Medicaid Beneficiaries under Age 21

FOR NON-COVERED SERVICE REQUESTS UNDER EPSDT

This form should be used *only* to request a non-covered service under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. A copy of this form is available at https://providers.vayahealth.com/service-authorization/epsdt.

Use additional sheets to supply any other information you think will support medical necessity and EPSDT criteria. Include evidence-based literature, if available. **Submit the completed, *signed* form to Vaya by mail, fax or email:**

BY MAIL:	BY FAX:	BY EMAIL:
Vaya Health Utilization Management 200 Ridgefield Court, Suite 206 Asheville, NC 28806	Vaya Health Utilization Management 877-260-6517	UM@vayahealth.com

I. BENEFICIARY INFORMATION

Name: **Sex:** ☐ Male ☐ Female

Date of birth: **Age:** **Medicaid ID:**

Address:

Legal guardian: **Address:**

Relationship: ☐ Parent ☐ DSS ☐ Other (specify): **Telephone:**

II. REQUESTOR INFORMATION

Name and credentials: **Medicaid provider #:**

Address:

Telephone: **Fax:**

III. PROVIDER INFORMATION

Name: ☐ No provider of requested service identified ☐ Provider is requestor

Medicaid Provider #: **Address:**

Telephone: **Fax:**

IV. REQUESTED SERVICE

Requested procedure, product or service:

CPT/HCPCS code(s):

Requested service intensity: **Anticipated service duration:**

Is the requested service a coverable service within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]?	☐ Yes ☐ No

Provide a description of how the requested procedure, product or service will correct or ameliorate the beneficiary's defect, physical or mental illness or condition (the problem) diagnosed by the beneficiary's treating provider. (This description must include a detailed discussion about how the service, product or procedure will improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.)

Has the requested service been determined to be medical in nature? Discussion:	☐ Yes ☐ No
Has the requested service been determined to be safe? Discussion:	☐ Yes ☐ No
Has the requested service been found to be effective for this beneficiary? Discussion:	☐ Yes ☐ No
Is the requested service generally recognized as an accepted method of medical practice or treatment? Discussion:	☐ Yes ☐ No
Is the requested service experimental or investigational? Discussion:	☐ Yes ☐ No

V. CLINICAL INFORMATION

In what capacity have you treated the beneficiary? (Include how long you have cared for the beneficiary and the nature of the care.)

What other treatment has the beneficiary received for this condition?

What outcomes were achieved?

What is the beneficiary's health history? (Include chronic illnesses.)

What is/are the recent diagnosis(es) related to this request? (Include onset and course of disease and beneficiary's current status.)

What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals and the beneficiary's response to treatment.)

What alternative products, procedures or services have been considered or tried?

VI. DOCUMENTATION

Please list and append to this request all supporting clinical documentation, including diagnostic evaluation reports, treatment plans, etc.

List of appended documents:

_____ _____

Requestor's signature and credentials **Date request submitted**

FOR VAYA HEALTH STAFF USE ONLY

Staff member receiving request: _____

Date request received by Vaya: _____

SAR number assigned: _____

Date request logged: _____

Request forwarded to: _____

Date request forwarded: _____

Comments: