



Request Date: \_\_\_\_\_

## MODIFICATION REQUEST FORM (MRF)

**PROVIDER NOTICE:** Modifications may not be accepted if decision has already been made or authorization is beyond regulatory turnaround time. For routine requests, this is 7 days for Medicaid and Medicare. Authorization does not guarantee payment. ELIGIBILITY must be verified at the time of service. Modifications of a referral can be made to update the following: ICD-10 or CPT/HCPCs, Number of Units and Provider/Facility name.

Authorization Request #: _____		Original Authorization Date: _____	
Patient Name (Last, First): _____		<input type="checkbox"/> Male	<input type="checkbox"/> Female
		DOB: _____	Age: _____
Patient Mailing Address: _____		City: _____	Zip: _____
Patient Phone: _____		Member ID & Health Plan: _____	
Requesting Provider Name: _____		Servicing/Requested Provider: _____	
Provider NPI #: _____		Provider NPI #: _____	
Provider TIN #: _____		Provider TIN #: _____	
Address: _____ Phone: _____		Address: _____ Phone: _____	
Fax: _____		Fax: _____	
Office Contact Name & Role: _____		Office Contact Name & Role: _____	
Servicing/Requested Facility (if applicable): _____			
Facility NPI #: _____		Facility TIN #: _____	
Address: _____			
Phone: _____		Fax: _____	
Office Contact Name & Role: _____			
Diagnosis: _____		ICD-10: _____	
Inpatient Admission Date (if applicable): _____			

### Original Requested Authorization

<input type="checkbox"/> Inpatient Facility	<input type="checkbox"/> Office	<input type="checkbox"/> Surgery Center / Outpatient	<input type="checkbox"/> Physician Administered / Part B Drugs
<input type="checkbox"/> SNF	<input type="checkbox"/> Medical Services/Items		

List ALL procedures requested along with the appropriate CPT/HCPCs and **submit supporting Medical Records.**

Requested Procedures	Code (CPT or HCPC)	Modifiers	Units (Required)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

### Requested Modifications

List ALL procedures requested along with the appropriate CPT/HCPCs and **submit supporting Medical Records.**

Requested Procedures	Code (CPT or HCPC)	Modifiers	Units (Required)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____