GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

BUREAU OF HEALTH CARE FINANCING ADMINISTRATION

PRIOR AUTHORIZATION FORM

Please submit your Prior Authorization (PA) request via facsimile to 671-735-7476 or email **with end-to-end encryption** to: PA@dphss.guam.gov or EPSDT@dphss.guam.gov. **SUBMIT ONE PA REQUEST TYPE PER FORM. STAT** services (delivered within 24-48 hours to treat a life-threatening condition or prevent further complications) do NOT require PA, but will be reviewed for medical necessity upon submission of claim(s). **This form should NOT be used for PA requests for Brand Name or Non-Formulary Drugs, Durable Medical Equipment and Supplies, Drug Prescriptions, Hospital Length-of-Stay, Off-Island Care, and multiple Physical Examinations.**

PATIENT INFORMATION	
Patient Name:	Date of PA Request:
Medicaid Number:	Patient Date of Birth:
PROVIDER/PHYSICIAN INFORMATION	
Servicing Provider/Clinic Name:	Servicing Provider/Clinic ID Code:
Referring Physician Name:	Referring Physician ID Code:
Physician Phone Number:	Physician Email Address:
PRIOR AUTHORIZATION INFORMATION	
Description of Diagnosis(es)	ICD-10 Code(s):
Description of Procedure(s)/Service(s) Requested:	CPT Code(s):
If PA requested for a diagnostic scan, please indicate whether scan is requested with or without contrast:	☐ With Contrast ☐ Without Contrast
Appointment Date & Time:	
Pertinent Signs/Symptoms:	
Treatment Received and Duration *(if applicable)*:	
Response to Treatment *(if applicable)*:	
Comments (include significant past medical history and/or co-morbidity):	

Please complete this form and attach supporting documents pertinent to this request for PA (such as x-ray, previous CT/MRI reports, consult notes, Medicaid/MIP Sterilization Consent Form, etc.), and, if applicable, the Screening, Abortion, Sterilization, Surgery Addendum, which is used for requests for a Screening Mammogram, Screening Pap Smear (not for contraceptive management), Abortion Procedure, Sterilization Procedure, or Elective Surgery (requiring admission 1+ day(s) prior to surgery).

If you have any questions, please contact a Customer Service Representative at 671-735-7473/4.

Bureau of Health Care Financing Administration
Phone: 671-735-7473 ◆ Fax: 671-735-7476
Email: PA@dphss.guam.gov or EPSDT@dphss.guam.gov

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SCREENING, ABORTION, STERILIZATION, SURGERY ADDENDUM

Please submit this PA addendum as an attachment to the Prior Authorization (PA) Request Form. This addendum provides additional information in support of a PA request for a Mammogram, Pap Smear, Abortion Procedure, Sterilization Procedure, or Elective Surgery (requiring admission 1+ day(s) prior to surgery).

ONLY fill out fields APPLICABLE to your request for PA.

PATIENT INFORMATION	
Patient Name:	Date of PA Request:
SCREENING MAMMOGRAM	
Does the patient have a history or family history of breast cancer?	☐ Yes ☐ No
SCREENING PAP SMEAR (NOT FOR CONTRACEPTIVE MANAGEMENT)	
Does the patient have a history or family history of cervical cancer?	☐ Yes ☐ No
Result of last Pap Smear:	
Notes on abnormal result *(if applicable)*	
ABORTION	
Reason for Abortion:	
STERILIZATION	
Type of Procedure:	
Counselor:	Date Consent Form signed:
ELECTIVE SURGERY, REQUIRING ADMISSION 1+ DAY(S) PRIOR TO SURGERY	
Planned Surgery:	Date of Surgery:
Name of Facility:	Date of Admission:
Justification for Early Admission:	

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