All fields may not be appropriate or necessary for all requests. **Please submit information based on EPSDT considerations reflected in the form that, in your judgment, may be pertinent/helpful for the specific case in aiding a determination of medical necessity.**

EPSDT Medical Necessity Form

Non-Covered State Medicaid Plan Services Request Form for Recipients *Under* 21 Years Old

1. **Recipient information**: This must be completed by a physician, licensed clinician or other provider.
   NAME: _____
   DATE OF BIRTH: _____(mm/dd/yyyy) MEDICAID ID NUMBER: _____
   ADDRESS: _____
   _____
   _____
   _____
   _____

2. **Medical Necessity**: All requested information, including CPT and HCPCS codes if applicable, as well as provider information, must be complete. Please submit records that support medical necessity.

   REQUESTOR NAME: _____ PROVIDER NAME: _____
   NPI: _____ NPI: _____
   ADDRESS: _____ ADDRESS: _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____
   TELEPHONE: _____ TELEPHONE: _____
   FAX: _____ FAX: _____
   REQUESTED PROCEDURE, PRODUCT OR SERVICE: _____

   CPT/HCPCS CODE: _____ /_____

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

4. **What is the recipient's health history?** (Include chronic illness.)
   _____
   _____
   _____
   _____

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

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

7. **Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem).** (**Must** include a detailed discussion about how the service, product or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.)

8. **Is this request for an experimental or investigational treatment?**
   _____YES _____NO
9. **Is the requested product, service or procedure considered to be safe?**
   _____YES _____NO
10. **Is the requested product, service or procedure effective?**
    _____YES _____NO
11. **Are there alternatives to the product, service or procedure requested that would be more cost effective but similarly medically effective?**
    _____YES _____NO
    If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available.

12. **What is the expected duration of treatment?**

REQUESTOR'S SIGNATURE & CREDENTIALS **DATE**

If you have questions about non-covered state Medicaid plan services, please reach out to the following plan-specific contacts:

Kansas Medical Assistance Program	Aetna Better Health of KS	Sunflower Health Plan	UnitedHealthcare Community Plan
PA Phone 800-933-6593 PA Fax 800-913-2229	PA Medical Phone 855-221-5656 PA Medical Fax 855-225-4102 PA Pharmacy Phone 855-221-5656 PA Pharmacy Fax 844-807-8453	PA Medical Phone 877-644-4623 PA Medical Fax 888-453-4756 PA Pharmacy Phone 877-397-9526 PA Pharmacy Fax 833-645-2740	PA Medical Phone 866-604-3267 UHCprovider.com PA Pharmacy Phone 800-310-6826 PA Pharmacy Fax 866-940-7328