

Ohio Department of Health

Children with Medical Handicaps Program (CMH)

Prior Authorization

Type or Print Legibly

Fax completed form to 614-564-2501

Provider Information

Number	NPI
Provider Name	
Street Address	
City, State and Zip Code	
Provider Telephone Number and Ext.	Provider Fax Number
Contact Person	Date Form Completed
Contact Email	

Client Information

CMH Case Number (12 digit number)	
Last Name	First Name
Street Address/Facility Name and Address	
City, State and Zip Code County	
Date of Birth	

This Request

From:	To
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Attach Prescription/Certification signed by the credentialed CMH physician or APN including the complete diagnosis medical history, degree of impairment and medical necessity. Give complete description of service or item including make, model, serial number, freight charges and NDC code.) Attach any additional supportive information.

Requested Services

	Quantity					Procedure Code										Usual and Customary Charge									
1.																									
2.																									
3.																									
4.																									
5.																									
6.																									

1. _____	4. _____	Dispense Date
2. _____	5. _____	
3. _____	6. _____	

Notes:

State Use Only - Do Not Complete Sections Below

	Quantity					Procedure Code										Approved Dollar Amount										Approve
1.																										
2.																										
3.																										
4.																										
5.																										
6.																										

Line No.	Comments	Reviewer
_____	_____	Date
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