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CABINET FOR HEALTH AND FAMILY SERVICES
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Eric Friedlander
SECRETARY

Lisa Lee
COMMISSIONER

Date:

****The following is the information needed from the social worker, case worker, parent, foster parent in order to provide prior authorization for travel assistance.****

1. Patient's Name:
2. Patient's DOB:
3. Patient's SSN#:
4. Medicaid ID #:
5. Managed Care Organization ID #:
6. Managed Care Organization Name:
7. Accompanying Parent Name:
8. Address:
9. Phone:
10. Referring Primary Care or Specialty Physician's Name:
11. Physician's Phone Number:
12. Physician's Address:
13. Name of Facility Where appointment is:
14. Facility Address:
15. Facility Phone Number:
16. Time(s) and Date(s) of appointments:
17. Name of Physician or Specialist:
18. Social Worker/Case Manager's Name and Phone Number: