THE OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

Medicaid Services System (MSS) - Create New PA Request (Page 1)

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DODD #: Medicaid #:

Waiver: **Type:** I/O **Status:** ENRL

Individual Request Form

Prior Authorization of Individual Options Waiver Services

PA #

***= Required Field**

The following individual is requesting the Ohio Department of Developmental Disabilities (DODD) initiate a prior authorization review because their service needs cannot be met within the designated Ohio Developmental Disabilities Profile (ODDP) funding range after completing the ISP meeting.

Individual Information

Name:		County of Residence:	
Medicaid Number:		Phone Number:	
DODD Number:		Address:	
I Live with:		City:	
		State:	OH
		Zip:	

Guardian Information (if applicable)

Name:		Address:	
Phone Number:		City:	
		State:	
		Zip:	

Authorized Representative Information (if applicable)

Name:		Address:	
Phone Number:		City:	
		State:	
		Zip:	

PA Contact Information

Name:		Phone:	*
Email Address:		County:	*

Total Dollar Amount Requested during the Noted Prior Authorization period: $

The Prior Authorization Request will be reviewed based only on the services and amounts listed with the CP.

The Individual's Full Waiver Span: _____

☐ The County Board attests that the IRF with Individual/Guardian Signature is kept on file.

Signature date on IRF Filed: *

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