Medical Day Care (MDC) Authorization Request Form

Fax completed form to **1-609-583-3048**

❑ **Adult Request** ❑ **Pediatric Request**

Please check type of request:

❑ Initial Request ❑ Re-Assessment ❑ Facility Transfer ❑ HMO Transfer ❑ Change Request
❑ With new MD order ❑ With Letter of Intent by member ❑ With Prior HMO Approval Letter

Date submitted to Horizon NJ Health:

Please provide the following member demographic information:

Member County:______________________________

Member Name: ____________________ Member ID: ____________ DOB: ____________

Member Address (Street/City): ______________________________

Member Phone: ____________________ Member Alternate Phone: ________________

Translation needed: ❑ Yes ❑ No If Yes, language: ________________

Please provide the following information:

Current authorization expires on: ________________ Day per week:________________

Has member had a lapse in service for 30 consecutive days during the prior authorization period? ❑ Yes ❑ No
(*ICD-10 codes are required for all requests and claims*)

Primary DX: ____________ ICD-10: ____________ Other Chronic DX:____________ ICD-10: ____________

Other Chronic DX:____________ ICD-10: ____________ Other Chronic DX:____________ ICD-10: ____________

Please check one of the following codes:

❑ Ped Med Day (technologically dependent) T1024 w/modifier 22 ❑ Adult Med Day S5102
❑ Ped Med Day (medically fragile) T1024 w/modifier 52

Change in service request ❑ Increase ❑ Decrease

Information to support service request change (must provide specifics) ______________________________

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Required additional information:

MDC Provider Name: ______________________________

Provider ID: ____________________ MDC Contact: ____________ Phone:____________

Address of facility where member attends:______________________________

Facility Phone____________________ Facility Fax:____________________

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