Horizon Blue Cross Blue Shield of New Jersey

Horizon NJ Health

MEDICAL DAY CARE REQUEST FORM

As of Oct. 1, 2015, ICD-10 codes are **required.**

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**

Date Submitted to HNJH:

Please provide the following member demographic information: Member County: #_____

Member Name:_____ HNJH Mbr ID#_____DOB:_____

Member Address *(Street/City)*_____

Member Phone #_____ Translation Needed: Yes / No If yes language: _____

Please provide the following information:

Current Authorization Expires on:_____ Requesting # days 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 *(Please circle):* Increase / Decrease

Information to support service request change *(must provide specifics):*_____

_____

REQUIRED ADDITIONAL INFORMATION*:*

Medical Day Care Provider Name: _____Provider ID#_____

Medical Day Care Contact : _____ Phone #_____

Address of Facility where member attends: _____

Phone # of Facility _____Fax # of Facility_____

Horizon NJ Health reserves the right to request necessary clinical information on a case-by-case basis.
Services should not be rendered without an authorization. Providing services without an authorization could result in a denial of payment.
All MDC services require prior authorizations.