# ARKANSAS DEPARTMENT OF HEALTH
## AUTHORIZATION FOR PRIOR APPROVAL

| Patient's Last Name | First | Sex<br>Female | Client ID No. |
|---|---|---|---|
| Date of Birth | | | |

| Service Requested | Requested by | Procedure code | Procedure date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**TO BE PROVIDED BY**
**(Use BreastCare Provider Number)**

| | |
|---|---|
| Physician | Provider No. |
| Group name | Provider No. |
| Hospital | Provider No. |

**Please check the appropriate boxes (Pathology Report Needed):**

☐ HGSIL or AGC Pap smear result with one or more of the following conditions

- ☐ Unsatisfactory colposcopy
- ☐ Only CIN 1 confirmed biopsy
- ☐ Satisfactory colposcopy with no lesion

☐ Other

**NOTE:**

*Breast*Care will make payment only to those providers who participate in the *Breast*Care Program. Please forward individual copies of the authorization to the appropriate providers.

Payment for physician services and hospital/radiation therapy facilities will be made according to:

1. State guidelines and
2. Eligibility of the recipient at the time the service is provided. Services should be billed to ADH only for recipients whose eligibility has been verified.

**PRIOR AUTHORIZATION CONTROL NUMBER:** _____

This number must be entered on the claim form or payment will be denied. Service must be performed before the end of the patient's eligibility date, which can be found on the ID Card.

_____ / /

Authorized By Date

Revised 04/26/2019