MEDICAID AUTHORIZATION FORM

Medicaid Authorizations are required in order for our physician to provide treatment. This is due to North Carolina State Medicaid Regulations.

Patient's Full Name: _____
(Must match insurance card)

Patients DOB: _____

Appointment Date/Time: _____

Name of Practice Referring to NC Neurology & Sleep: _____

Name of Physician Referring to Dr. Giallanza: _____

NPI/Authorization Number: _____

Authorized Number of Visits: _____

Authorized Signature: _____

Printed Name of Authorizer: _____

Authorized Start Date: _____ End Date: _____

Provider's Comments: _____

PLEASE FAX TO: (704)-464-1393

Prior to Appointment Date

Effective November 1, 2016, North Carolina State Medicaid mandated that written confirmation of authorizations must be issued from Referring Practices. If this authorization form is not received prior to the patient's appointment, the patient will not be seen.

Thank you,

NC Neurology & Sleep

RESET FORM