MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

North Carolina DMA Request Fax Form

north carolina medicaid

Fax requests to MedSolutions at 888.693.3210. Status can be checked by phone at 888.693.3211.
In some cases, more clinical information is required. MedSolutions reserves the right to request more detailed information for the patient.

Please indicate case number (if available) :	
Select ONE of the following four scenarios :	
☐	Patient granted retroactive eligibility (12 months back or first day of program): • Provide clinical information to support medical appropriateness • Initial here _____ to acknowledge the date of services (DOS) is within the retro eligibility period and provide retro-effective add date (if available) _____(MM/DD/YYYY)
☐	Patient misrepresents Medicaid coverage on date of service: • Provide evidence of registration error and clinical information to support medical appropriateness
☐	CPT® code changes: • Downcoding (lower intensity service) ◦ No supporting clinical information required ◦ May also send secure email to *authchange@medsolutions.com* with request • Upcoding (higher intensity service) and/or additional codes not approved prior to delivery of service ◦ Provide copy of the imaging reports and supporting clinical information to support medical appropriateness of coding change
☐	Facility location mismatch: ◦ Provide copy of the imaging report to document location of services – must be an enrolled site

Member

Patient First Name:		Patient Last Name:		
DOB:	Member ID:	Group #:	Health Plan:	
Address:		City:	ST:	Zip:

Physician

Physician First Name:		Physician Last Name:		
Primary Specialty:	NPI:	Tax ID:		
Address:		City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:		

Facility

Facility Name:	Facility NPI:	Facility Tax ID:	
Address:		City:	ST:	Zip:
Phone #:	Fax #:	NPI:	☐ RETRO Date of Service:
ICD-9 Code (Required Field):			
Enter CPT® code(s):			
☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast			

Contact

Check the appropriate box describing the responsible contact: ☐ Ordering Physician ☐ Facility ☐ Other: _____

Person to Call for Contact:_____

Phone Number for Contact: _____

Date this request submitted: _____