# 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) _____

_____

_____

*Required additional information:*

MDC Provider Name: _____

Provider ID: _____ MDC Contact: _____ Phone: _____

Address of facility where member attends:_____

Facility Phone_____ Facility Fax:_____

**horizonNJhealth.com**