Pediatric Respite Authorization Form

Please complete ALL sections of this form. Fax the completed form and any supporting documentation, including the prescription, to Delaware First Health Prior Authorization at 1-833-967-0502. **Authorization is based on medical necessity. Incomplete information or illegible forms will delay processing.**

Submission Date:

MEMBER INFORMATION		
Member Name:	Member ID:	Date of Birth:
Diagnoses:	ICD-10 Code(s):	

REQUESTING FMS (Financial Management Service), Agency or Provider	
Provider Name:	Provider NPI Number:
Provider Address:	
Provider Phone Number:	Provider Fax Number:
Primary Contact Name:	Contact Phone Number:
SERVICING FMS (Financial Management Service), Agency or Facility Provider	
Provider Name:	Provider NPI Number:
Provider Address:	
Provider Phone Number:	Provider Fax Number:
Primary Contact Name:	Contact Phone Number:

REQUEST TYPE: ☐ New Request ☐ Ongoing Request

IN-HOME UNSKILLED RESPITE				
Procedure Code	Code Description	Start Date	End Date	Number of Units or Hours
IN-HOME SKILLED RESPITE				
Procedure Code	Code Description	Start Date	End Date	Number of Units or Hours
OUT OF HOME RESPITE				
Procedure Code	Code Description	Start Date	End Date	Number of Units or Hours
EMERGENCY RESPITE				
Procedure Code	Code Description	Start Date	End Date	Number of Units or Hours

Requesting Provider (Signature):

Requesting Provider (Print): Date: