

Prior Authorization Change Request Form



Submit by email or fax at: **Email:** MSMedicaidUM@Telligen.com | **Fax:** 800-524-5710

The PA Change Request Form is to be used for PA requests that are in progress or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs. Submit this form by **Email or Fax only**.

Member Information	
Member Name:	
Medicaid ID:	

Provider Information	
Contact Name:	
NPI:	
Phone Number:	
Today's Date:	

Case ID Number		
Request ID Number:		
Prior Authorization Number:		
Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.		
Examples: Add/Change Modifier: Add "RR" to "E1088"		
Correct Date(s) of Service: Change requested effective date from 08/01/2023 to 10/01/2023		
Add/Change Modifier:		
Correct Number of Unit(s):		
Correct Place of Service:		
Correct Diagnosis Code(s):		
Correct Date(s) of Service:		
Correct Provider ID:		
Correct Provider ID:	Gainwell Provider ID:	
	Physician Name:	
	Address Location:	
Reconsideration Reopen Reason (Tech Denial)		
Comments:		

Note: Telligen cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. This form must be received within **90 days** of the date of the approval on the PA decision letter.

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