CHESTER COUNTY

REQUEST FOR ADDITIONAL UNITS

CLINICAL RATIONALE AND MEDICAL NECESSITY

Members Name: **Authorization #:**

Member's ID: **Procedure/Location:**

# of Additional Units Requested: **New Total Units Authorized:**

NUMBER OF UNITS UTILIZED BUT NOT CURRENTLY BILLED:

WHAT HAS BEEN HAPPENING THAT REQUIRES ADDITIONAL UNITS?

HOW WILL THE ADDITIONAL UNITS BE USED?

WHAT IS THE ANTICIPATED RESPONSE FROM THE INDIVIDUAL?

WHAT IS THE STATUS OF MEDICAL ASSISTANCE?

STAFF SIGNATURE/DEGREE:

DATE OF REQUEST:

E-mail request to: mhauths@chesco.org