

LIMITED SERVICE AUTHORIZATION

Recipient name _____

Recipient Medicaid number _____

Date of service(s) _____

Service(s) provided _____

Medicaid procedure code(s) _____

I have reviewed the relevant clinical information and confirm that the service(s) provided was (were) medically necessary.

Treating Practitioner's Signature

Date

Treating Practitioner's Name

To be placed in the recipient's medical record.