

**Request for Extension of Administrative Authorization of Services  
due to Fair Hearing**

**Fax: 1-855-677-3747**



**Health**  
SOLUTIONS

**Request Date:** \_\_\_\_\_

**RECIPIENT INFORMATION**

Recipient Name: Last, First, Middle  
\_\_\_\_\_

Medicaid ID #:

Date of Birth:   /   /

Sex:  Age:

**REQUESTOR AND PROVIDER INFORMATION**

**TYPE OF SERVICE**

Requestor's Name: \_\_\_\_\_

Requested by:  Facility  Physician  Recipient/Representative

Phone #: ()  -

Ext.

Fax #: ()  -

Email: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider's Medicaid ID #:

Indicate the service the Recipient is to/was receiving:

Behavior Analysis Services

**REQUEST FOR EXTENSION OF ADMINISTRATIVE AUTHORIZATION OF SERVICES DUE TO FAIR HEARING**

Review ID #:

eQHealth Case ID#:

Date of Admission/Start of Service:   /   /

Date of Discharge, if applicable:   /   /

**Please extend the administratively authorized services for the above identified recipient. I acknowledge that this request is valid through the current certification period. At the end of the certification period, if the final order is not rendered, I will submit a request for another extension. When the Fair Hearing Officer issues the final written order for the identified recipient, the authorization will be modified as ordered. I understand it is my responsibility to maintain all required documentation to submit for a continued stay review.**

**Signature of Requestor / Provider**

**Print Name of Requestor / Provider**