|  |  |  |
| --- | --- | --- |
| DDAP-EFM-1004 12/15 | **Authorization**(Required fields are in **BOLD**) | **Provider Location:**       **Provider Name:**       **DDAP License #:**        |
| **UCN:** |       |  |  |
| **First Name:** |       | M.I.: |    | **Last Name:** |       | Suffix: |       |  |
|  |  |  |  |  |  |  |  |  |
| **Authorization Request – TO BE COMPLETED BY PROVIDER** |
| **Scheduled Admit Date:** |       |  | **Date of Request:** |       |  |
| **Requested From**: |       |  | **Requested To:** |       |  |
|  |
|  | **Requested Services** | **Units** | **UOM** |  |
|  |       |       |  |  |
|  |       |       |  |  |
|  |       |       |  |  |
|  |       |       |  |  |
| Comments: |       |
| **Authorization Approval – TO BE COMPLETED BY SCA** |
| [ ]  Entire Request Denied |  |  |
| Reason for Denial: |       |  |
| If approved, please complete the following fields: |  |
| **Authorization #: ##Number**: |       |  | **Date of Issue:** |       |  |
| **Valid From**: |       |  | **Valid To:** |       |  |
| **Funding Source:** |  |  |  |  |
|  List Other Funding Source: |       |  |
|  |  |  |  |  |
|  | **Authorized Services** | **Units** | **UOM** |  |
|  |       |       |  |  |
|  |       |       |  |  |
|  |       |       |  |  |
|  |       |       |  |  |
| Comments: |       |

Form to be submitted to SCA if required by the SCA.