

Maryland Department of Health and Mental Hygiene

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary, DHMH
Office for Genetics and Children with Special Health Care Needs
Children's Medical Services

Request for Pre-Authorization of Services

Return to:

201 W. Preston St., Room 421A, Baltimore, MD. 21201

Phone: 410-767-5588

Fax: 410-333-7956

Referral to:

MA Provider #: _____

Provider's Name: _____ Facility/Clinic: _____

Phone: _____ Fax: _____

Child's Name: _____ Birth Date: _____
Last First MI

Child's SSN/CMS#: _____ - _____ - _____ MA#: _____

County or Baltimore City: _____ Phone: _____

Health Insurance: _____
Name and Policy Number

Diagnosis: _____

Reason for Referral: _____ Clinical Notes Attached: Y N

Service(s) Requested: In-Patient Clinic Dental Other: _____

Dates:

Begin	End	CPT Code	Procedure or Service	Number Of Services	Estimated Charge
1. ___/___/___	___/___/___	_____	_____	_____	_____
2. ___/___/___	___/___/___	_____	_____	_____	_____
3. ___/___/___	___/___/___	_____	_____	_____	_____

Signature of Individual Completing Form Telephone _____ / /
Date of Request

Title/Agency
Send Authorization to:

Name/Agency

Street

City *Zip Code*

Telephone *Fax*

For Office Use Only
Service Type _____ CA Item _____
Approved Initial _____ Date _____
On Line Save Initial _____ Date _____
Bill Approved Initial _____ Date _____
Authorization #: _____
Comment _____

Maryland Department of Health and Mental Hygiene
Office for Genetics and Children with Special Health Care Needs
Children's Medical Services (CMS)

Request for Pre-Authorization of Services

Instructions for Completion of Form 4510

NOTE: All providers must initiate and complete Form 4510. CMS regulations, Children's Medical Services Program (COMAR 10.11.03), mandate that the Providers of service request authorization on forms designated by CMS. The Provider must initiate this process via Form 4510 when service to a CMS eligible patient is anticipated. Mail or FAX the completed form to CMS as directed on Form 4510.

Provider#

Enter the Provider's Medical Assistance Provider Number which will be used for billing for the type of service to be provided.

Provider/Facility

Insert the name of the Provider/Facility and Clinic which the service will be billed.

Phone and Fax

Enter the appropriate numbers to the areas where the service will be provided.

Child's SSN/CMS#

Insert the patient's nine (9) digit Social Security Number or CMS number.

County or Baltimore City

Enter the patient's county of residence or "CITY" for Baltimore City residents.

Health Insurance

If applicable, enter the patient's private insurance company's Name and policy number.

Diagnosis

Enter the patient's diagnosis or description of problem which relates to this request.

Service(s) Requested

Check the appropriate block. Add a comment to specify "Other".

Lines 1-5

Begin, End – Enter a specific date under "Begin" and "End" if possible or indicate range of dates within which you anticipate providing the service.

CPT Code – Enter the five (5) digit Medicaid billing CPT or HCPCS code for all services excluding hospital facility services.

Procedure – Enter a description of the procedure,

item or service.

Number of Services – For non-hospital services, enter the number of services.

Estimated Charge – Enter an estimate of the charge for the service.

Signature, Title and Telephone

Enter the person who will respond to questions from CMS staff about the request. Date the request.

Send Authorization to:

Enter the person and/or office address to which the CMS written authorization should be sent.

Telephone/ FAX

Enter the numbers of the office which should receive the written CMS authorization.