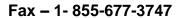
## Request for Extension of Administrative Authorization of Services due to Fair Hearing





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 #: (	Indicate the service the Recipient is to/was receiving:  Home health visits  Private duty Nursing/Personal Care Services  Physical Therapy  Occupational Therapy  Speech-language Pathology
REQUEST FOR EXTENSION OF ADMINISTRATIVE AUTHORIZATION OF SERVICES DUE TO FAIR HEARING	
eQHealth Case ID#:	ate of Admission/Start of Service:
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

Effective: 09/29/2011 Reviewed: February 2019