MPW PRIOR APPROVAL INSTRUCTIONS

Prior approval from EDS is required for coverage of Home Health Services, Home Infusion Therapy, Hospice and Personal Care Services for MPW recipients. When a MPW patient is referred to you for one of these services, review the requirements for MPW coverage in 2.14 and the coverage criteria for the requested service with the patient's attending physician. If the patient appears appropriate for coverage, complete the Medicaid "Request for Prior Approval" (form 372-118) with the physician's assistance. Blank forms are available from EDS at the number in Appendix B, WHO TO CONTACT.

Complete the form as follows:

1. PRIOR AUTHORIZATION NUMBER	Leave blank. If prior approval (PA) is granted, EDS will enter the PA number here.
2. PATIENT NAME	Enter the Medicaid patient's last name, first name and middle initial as it is on the Medicaid ID card.
3. MEDICAID IDENTIFICATION NUMBER	Enter the patient's Medicaid ID number as it is on the Medicaid ID card.
4. DATE OF BIRTH	Enter the patient's date of birth as it is on the Medicaid ID card.
5. DIAGNOSIS	Enter a written description of the patient's diagnosis.
6. ICD 9TH EDITION	Enter the ICD-9-CM diagnosis code(s) for the entry(ies) in **5**.
TYPE OF REQUEST	Leave blank.
7. BRIEF SUMMARY OF CLINICAL FINDINGS	Give a brief description of the clinical findings applicable to this request.
8-9 RETROACTIVE DATE(S) REQUESTED	Leave blank.
10. PROCEDURE TO BE PERFORMED	Describe the service for which PA is being requested and its expected duration. For **Home Health**, include the type and frequency of visits. For **PCS**, include length and frequency of visits. For **HIT**, show the type of HIT coverage. If **EN** or **TPN**, give details of the supplies, equipment and formulae involved. For **Hospice**, indicate the level of care and services needed.
11. PROCEDURE CODE	List Revenue or HCPCS code(s) applicable to the service(s) in **10.**
12. REASON PROCEDURE IS NECESSARY TO PATIENT'S HEALTH	Include information from the patient's physician detailing the complications of the pregnancy, the reason the service is medically necessary and the potential adverse impact that may occur if the service is not provided.
13. HAS PATIENT BEEN PREVIOUSLY…	Complete section as applicable. If "No," proceed to **14**. If "Yes," complete additional lines (a) and (b).
14. PHYSICIAN SIGNATURE	The physician signs here. Stamped signatures are not acceptable.
15. DATE	The physician enters the date of signing here.
16. PROVIDER'S NUMBER	Enter your seven-digit Medicaid provider number for the service requested.
17. PLACE OF SERVICE	Not required.
18. PROVIDER'S NAME AND MAILING ADDRESS	Type, print or stamp your agency's name and address as it appears on the Remittance and Status Report.

Mail the completed form to the address in Appendix B.

The EDS medical director will review the information in the PA request to determine if the service may be covered. A copy of the PA form will be returned to you with the decision. If the request is approved, EDS assigns a prior approval number. PA is retroactive to the date of the first visit ordered by the physician according to Medicaid policies and procedures. Enter the PA number on the claim form as instructed in Section 14.

REMEMBER: *PA does not guarantee payment. It only authorizes payment if the other prerequisites to payment are met, including the patient being on Medicaid on the date of service and meeting all of the coverage criteria.*

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