Standardized Prior Authorization Form Instructions

The Standardized one-page Prior Authorization Request Form is to be used by all NH Medicaid Fee for Service (FFS) and Managed Care Organization (MCO) service providers to obtain service authorization for their Medicaid-enrolled beneficiaries for specific services that require service authorization. **This does not substitute NH Medicaid Fee-for-Service or NH Medicaid Managed Care Organization Service Authorization policies and a copy of all supporting information is still required.** The following instructions provide information on how to complete all items on the form and include a list of acronyms at the end of the document. The instructions provide details about each item and explain the nuances of how to answer the items. A copy of the standard prior authorization form with corresponding numbers to the items in these instructions can be found on the last page of this document.

Services Covered:

The form should be used for all MCO and NH Medicaid FFS services requiring authorization with the exception of:

1- Behavioral health services
2- Radiology
3- NEMT
4- Pharmacy in most instances, see item 3 below for clarification
5- DME for Well Sense and NH Medicaid FFS. NHHF uses the form for DME at this time.

Information is entered on the Standardized Prior Authorization Request form in several ways:

1. Writing in specific data including dates, numbers, narrative (e.g., Items 1, 1b, 13, and 14)
2. Checking boxes (e.g., Items 1a, 2, 3, and 4)
a. Select one
b. Select all that apply
3. Writing in comments (e.g., Item 29)

Introduction:

1. Health Plan: Enter name of authorizing entity (i.e. New Hampshire Healthy Families, Well Sense, NH Medicaid Fee for Service).

1a. Please choose one:

For Urgent: Determinations made within 72 hours of the receipt of request, where application of the timeframe for making standard determinations could:

- Seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Standard: Determinations that are not urgent.

Note: Emergency services to screen and stabilize the member do not require approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

1b. Health Plan Fax #: Enter authorizing entity fax number including area code (e.g., 603-555-1234)

Service Type Requiring Authorization (check all that apply):

2. **Ambulatory/Outpatient Services:**
   Surgery/Procedures: This should be selected if the request is for a surgery or procedure. If the surgery or procedure will be inpatient please also check the inpatient box and indicate the planned admission date in box #25.

   Chiropractic: This should be selected if the request is for chiropractic services

3. **Pharmacy:** Select this for medication requiring authorization when covered as part of the medical benefit. Other medication authorizations are processed/authorized through the PBM. For FFS, indicate where the infusion is taking place.

4. **Home Health/Hospice:** For services performed **in the home** please select all specific services that apply. If selecting more than one service please specify in the comment section under Authorization Request (box #29) the requested number of visits or units and date range for each service requested. If selecting home health, please circle all services that apply. If the member lives in a nursing home or other residential facility, this is considered their home and these would be considered in home services. If services are not provided in the home, please use Outpatient Therapy (box #5).

   For Personal Care Attendant services please include the Self Care and Function Evaluation (SCFE) form.

5. **Outpatient Therapy:** Select the appropriate therapy type when the request is for these services to be performed in an outpatient setting. Please indicate the proposed start and end date and the number of visits/days or units in the authorization section. For NH Medicaid Fee for Service, please provide the revenue code and CPT codes under "Additional Comments," (box #29).

6. **Inpatient Care/Observation:** These are all general inpatient service classifications based on location/duration or severity of service needed. An admission date is required in box #25. Notification is required in advance of the admission or within 24 hours of admission if the admission was an emergency. As of February 2016, skilled nursing facilities are currently not covered by the MCO's. For NH Medicaid Fee for Service, please provide revenue codes under "Additional Comments," (box #29) for inpatient care in out-of-state hospital.

7. **Nutrition:** Select one of these when requesting the medical benefit to cover these services.

8. **Dental:** Select this service type for MCO covered anesthesia if required for dental procedures. Select miscellaneous for NH Medicaid covered dental services. Further specifications should be provided in box 10 "Other-please specify service." Please include dollar amount for NH Medicaid Fee for Service.

9. **Out of Network Request-please specify service:** Any out of network service request should have a notation here. If there is not service type category listed please note the specific service. For example, office visits or consults to out of network providers require authorizations.

10. **Other-please specify service:** Anything that does not meet the guidelines of the listed service types should be indicated here. For example, a second appointment on the same day at a FQHC.

    For NHHF, request DME in this section.

Member Information:

11. Member ID: For Managed Care, enter member's unique MCO identification number
For NH Medicaid Fee for Service, enter member's unique Medicaid identification number

12. Date of Birth: Enter member's date of birth; Month/Day/Year (e.g., 01/01/2012)

13. Last Name, First Name: For Managed Care, enter member's name as it appears on the MCO card
For NH Medicaid Fee for Service, enter member's name as it appears on the Medicaid card

Requesting Provider:

14. Requesting NPI: Enter the requesting provider's NPI Number. For NH Medicaid Fee for Service, please provide the NH Medicaid provider number.

15. Requesting TIN: Enter the requesting provider's TIN.

16. Requesting Provider: Enter name of the provider who is requesting the service authorization

17. Contact at Requesting Provider's Office: Enter name of the provider office contact that can answer questions/clarify information on Standardized Prior Authorization Request Form
17a. Phone: Enter contact's business phone number including area code (e.g., 603-555-1234)
17b. Fax: Enter contact's business fax number including area code (e.g., 603-555-5678)

Servicing Provider/Facility Information:

Note: Complete this section even if the Requesting Provider is the Servicing Provider.

18. Please choose one: For Managed Care, select whether the provider is participating or not in the health plans provider network
For NH Medicaid Fee for Service, select whether the provider is participating or not in NH Medicaid

19. Servicing NPI: Use the NPI of the billing provider. For NH Medicaid Fee for Service, please provide the NH Medicaid provider number.

20. Servicing TIN: Use the TIN of the billing provider.

21. Servicing Provider: Enter name of provider that will be performing the requested service.
21a. Servicing Facility Name: Enter name of facility that will be performing the requested service.

22. Servicing Provider Contact Name: Enter name of service provider office contact that can answer questions or clarify information
22a. Phone: Enter contact's business phone number including area code (e.g., 603-555-1234)
22b. Fax: Enter contact's business fax number including area code (e.g., 603-555-5678)

Authorizion Request:

23. **Primary Procedure Code(s):** Indicate the exact procedure code you are looking to have authorized

24. **Additional Procedure Code(s):** Add any additional codes that you are seeking authorization for. If you are unsure if you will be performing the additional codes, consider adding them for authorization to avoid claims issues after the fact.

25. **Start Date OR Admission Date:** The planned start date or admission date. If this is an emergency admission please include the actual admission date.

26. **End Date OR Discharge Date**: If the service has a planned end date, please indicate it. If the discharge has occurred please indicate what the discharge date was.

27. **Diagnosis Code:** Indicate the diagnosis code (version ICD-10)

28. **Total Units/Visits/Days:** Some services like visiting nurse or pain management have planned days or visits. Please indicate what is being requested, days or visits and how many.

29. **Additional Comments:** Any comments to help process the request.

Contacts:

For questions resulting from completing the form for NH Medicaid FFS or the MCOs please contact:

NH Medicaid FFS – 603-271-9384 (phone)
603-271-8194 (fax)
New Hampshire Healthy Families – 866-769-3085 (phone)
866-270-8027 (main fax)
877-658-0322 (STRS fax)
Well Sense – 877-957-1300 (phone)
603-218-6634 (fax)

Acronym List:

ABA	Applied Behavior Analysis
DME	Durable Medical Equipment
FFS	Fee for Service
FQHC	Federally Qualified Health Center
HHA	Home Health Aid
ID	Identification

MCO	Managed Care Organization
MSW	Master Social Worker
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergent Medical Transportation
NPI	National Provider Identification Number
OT	Occupational Therapist
PBM	Pharmacy Benefit Management
PT	Physical Therapist
SCFE	Self Care and Function Evaluation
SN	Skilled Nursing
ST	Speech Therapist
TIN	Tax Identification Number

02/2016

Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM".

A COPY OF ALL SUPPORTING INFORMATION IS REQUIRED. LACK OF INFORMATION MAY RESULT IN DELAY OR DISMISSAL OF REQUEST.

Prior Authorization request form and required clinical information should be sent to: NEW HAMPSHIRE HEALTHY FAMILIES or WELL SENSE HEALTH PLAN or State of NH

Health Plan:	□ Urgent □ Standard	Health Plan Fax #:

Service Type Requiring Authorization *(Check all that apply)*

Ambulatory/Outpatient Services □ Surgery/Procedure □ Chiropractic **Pharmacy** □ Systemic Immunomodulators □ Hyaluronic Acid Derivative Injections	**Home Health/Hospice** □ Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) □ Personal Care Attendant (Please include SCFE form) □ Hospice □ Infusion Therapy	**Outpatient Therapy** (Out of Home Only) □ Occupational Therapy □ Physical Therapy □ Speech Therapy □ Pulmonary/Cardiac Rehab □ ABA Therapy
Inpatient Care/Observation □ Acute Medical/Surgical □ Long Term Acute Care □ Acute Rehab □ Skilled Nursing Facility □ Observation	**Nutrition** □ Nutritional Counseling □ Enteral Nutrition □ Infant Formula □ Total Parental Nutrition	**Dental** □ Anesthesia □ Misc (specify in other below) □ **Out of Network Request—please specify service:**

□ **Other—please specify service:**

Member Information (*Denotes required field)

*Member ID:	*Date of Birth:
*Last Name, First Name:	

Requesting Provider Information (*Denotes required field)

*Requesting NPI:	*Requesting TIN:	*Requesting Provider:	
Contact at Requesting Provider's Office:		*Phone:	*Fax:

Servicing Provider/Facility Information (*Denotes required field)

***Please choose one:** □ Participating □ Non-participating	*Servicing NPI:	*Servicing TIN:
*Servicing Provider:	*Servicing Facility Name:	
*Contact at Servicing Provider's Office:	*Phone:	*Fax:

Authorization Request (*Denotes required field)

*Primary Procedure Code(s):	*Start Date OR Admission Date:	*Diagnosis Code:
	End Date OR Discharge Date:	Total Units/Visits/Days:
*Additional Procedure Code(s):	Additional Comments:	

Please refer to the following payer web sites for additional information regarding plan specific requirements for services that require prior authorization.

New Hampshire Healthy Families	Well Sense Health Plan	NH Medicaid Fee-For-Service
www.NHHealthyFamilies.com	www.Wellsense.org	www.nhmmis.nh.gov