

Inpatient Prior Authorization Request Form
DMAS/KePRO

**“KePRO/DMAS now require any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip codes then please visit:
<http://zip4.usps.com/zip4/welcome.jsp>”**

Submit fax request for prior authorization to: 1-877–OKBYFAX (877-652-9329). Requests may be submitted up to 30 days prior to scheduled procedures/services, provided the Enrollee is eligible.

Recert: Enter previous PA#. Change or Cancel: enter PA# to be changed or canceled.
PA #

1. <input type="checkbox"/> Initial <input type="checkbox"/> Recertification <input type="checkbox"/> Change <input type="checkbox"/> Cancel				
2. Date of request: (mm/dd/yyyy) / /		3. Review Type: (Please check one if applicable) <input type="checkbox"/> Retrospective Prepayment Review (Date notified of eligibility / /) <input type="checkbox"/> Retroactive MCO disenrollment		
4. Enrollee Medicaid ID Number (12 Digit number):		5. Enrollee Last Name:	6. Enrollee First Name:	
7. Date of Birth: (mm/dd/yyyy) / /		8. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	9. a. NPI/API Submitting Provider Name: b. Medicaid ID Number: c. 9 digit Zip Code (Mandatory)	
10. a. NPI/API Facility Name: b. Medicaid ID Number: c. 9 digit Zip Code (Mandatory)	11. Treatment Setting: <input type="checkbox"/> Inpatient	12. Surgical Admission: <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Admission Date: (mm/dd/yyyy) / /	14. Admission Status: <input type="checkbox"/> Urgent <input type="checkbox"/> Elective
15. Primary Diagnosis Code/Description: (enter up to 5) 1. 2. 3.				
16. Number of Days Requested:	16. Attending Physician Medicaid ID Number/NPI:		17. PA Service Type: <input type="checkbox"/> 0093 EPSDT Inpatient (Free standing) Psych <input type="checkbox"/> 0200 Intensive Rehabilitation <input type="checkbox"/> 0400 Inpatient Admission <input type="checkbox"/> 0401 Inpatient Psychiatric	
18. Procedure Code/Description:		19. Procedure Scheduled Date: (mm/dd/yyyy) / /		
20. Severity of Illness (Clinical indicators of illness including abnormal findings):				
21. Intensity of Services (Proposed/Actual monitoring and therapeutic services):				
22. Additional Comments (See Instructions):				

23. Contact Name:
24. Contact Telephone Number:
25. Contact Fax Number:

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Additional Information

21. Severity of Illness:

22. Intensity of Services:

23. Additional Comments (See Instructions):

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INSTRUCTIONS FOR ELECTRONIC FAX FORM

www.dmas.kepro.org
www.dmas.virginia.gov

This FAX submission form is required for inpatient Prior Authorization Review, Admission, Concurrent Review and Retrospective Review. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on **KePRO** forms can be entered. Do **not** send attachments or non-**KePRO** forms.

If KePRO determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (<http://dmas.kepro.org>) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a \surd or **X** in the appropriate box.
 - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
 - **Recertification:** A request for continued services (items) beyond the expiration of the previous preauthorization would be a recertification request.
 - **Change:** a change to a previously approved request; the provider may change the notes fields. The provider may not submit a "change" request for any item that has been denied or is pending.
 - **Cancel:** Use to cancel all or some of the items under one preauthorization number. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
2. **Date of Request:** The date you are submitted the prior authorization request.
3. **Review Type:** Place a \surd or **X** in the appropriate box. Please refer to the Retrospective review policy and procedure for each service detailed information regarding the submission of a Retrospective Review request. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Enrollee Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.
5. **Enrollee Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
6. **Enrollee First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.

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7. **Date of Birth:** Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Sex:** Please place a or **X** to indicate the sex of the patient.
9. **a. NPI/API Submitting Provider Name and Medicaid ID Number:** Enter the requesting physician's name and Medicaid ID number, national provider identifier or atypical provider identifier.
b. 9 Digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.
10. **a. NPI or API/Facility Name and Medicaid ID Number:** Enter the name and Medicaid Identification number, national provider identifier or atypical provider identifier of the hospital where the physician is requesting that the patient be admitted.
b. 9 Digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.
11. **Treatment Setting:** Place a or **X** to indicate the place of service.
12. **Surgical Admission:** Indicate if this admission is surgical by placing a or **X** for yes or no in the appropriate box.
13. **Admission Date:** Indicate the planned admission date using the mm/dd/yyyy format.
14. **Admission Status:** Place a or **X** for Urgent/Elective admission. This refers to the clinical status of the patient that is being admitted.
15. **Primary Diagnosis Code/Description:** Provide the **primary diagnosis code and description** indicating the reason for admission. You can enter up to 5 admission descriptions and ICD-9 codes.
16. **Number of days requested:** Based on your judgment provide the number of days requested for this admission diagnosis. Knowledge of InterQual/DMAS criteria will be extremely helpful.
17. **Attending Physician Medicaid ID Number/NPI:** Provide the Attending Physician's Medicaid ID number or national provider identifier.
18. **PA Service Type:** Place a or **X** to indicate if this is a EPSDT Inpatient Psych, Intensive Rehabilitation, Inpatient Admission, or Inpatient Psychiatric admission.

<i>Med\Surg</i>	Claim must reflect a med/surg primary diagnosis code for this authorization to be valid and reimbursement to be made.
<i>Psychiatric</i>	Claim must reflect a primary diagnosis code within the ICD 9 cm range of 290 thru 319 for this authorization to be valid and reimbursement to be made.

19. **Procedure Code/Description:** Provide the ICD-9 procedure code and description to indicate the reason for the patient's admission. Be sure that the procedure code is **an ICD-9 code**.
20. **Procedure Scheduled Date:** If the procedure is scheduled on a different day from the planned admission date, indicate the date of the procedure (mm/dd/yyyy).
21. **Severity of Illness (Clinical indicators of illness including abnormal findings)*:** One of the most important blocks on the form is the Severity of Illness. Knowledge of the

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InterQual/DMAS criteria will be helpful to provide pertinent information. Provide the clinical information of chief complaint, history of present illness, pertinent past medical history and previous treatment to substantiate the need for hospitalization and level of service for the requested admission/procedure. This field must include pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities. Include supportive diagnostic outpatient procedures and abnormal finding on physical examination. This information also assists the reviewers in further assessing the patient's condition. (Always include dates, types & results [with dimensions/% as appropriate]). Include TDO (Temporary Detention Order) date if applicable.

22. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:** This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information. This field must include the treatment plan for the patient while in the facility. List the services, procedures, or treatments that will be provided to the patient while in the facility.
23. **Additional Comments:** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the length of stay. For example, if a patient has been treated several times as an outpatient and failed therapy or has not followed through on treatment, then information of this sort should be placed here. For psychiatric cases, list the DSM-IV if available. For recipients admitted to freestanding facilities, CSB information is required. CSB information includes the screeners name, the date of the screening, the locality and the screeners title.
24. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.
25. **Contact Phone Number:** Enter the phone number with area code of the contact name.
26. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

****Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.***

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.