



Community Based Care Request for Services Form

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 code then please visit: <http://zip4.usps.com/zip4/welcome.jsp>

Fax: 1-877-OKBYFAX (877-652-9329) Phone: 1-888-827-2884

1. <input type="checkbox"/> New Request					<input type="checkbox"/> Change Request -- PA #					<input type="checkbox"/> Cancel Request -- PA #					<input type="checkbox"/> Transfer									
2. Date of Request: (mm/dd/yyyy) / /					3. Review Type: (Please check one) <input type="checkbox"/> Waiver Enrollment <input type="checkbox"/> Waiver Enrollment – Retrospective Review {Date notified of eligibility / /} <input type="checkbox"/> Service Request – If a Retrospective Review {Date notified of eligibility / /}																			
4. Enrollee Medicaid ID Number (12 Digit #):					5. Enrollee Last Name:					6. Enrollee First Name:					7. Date of Birth: (mm/dd/yyyy) / /					8. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female				
9. a. Service Provider Name:										10. Primary Diagnosis Code/Description:														
b. NPI/API Provider ID Number:										a. _____														
c. 9 digit Zip Code (Required)										b. _____														
										c. _____														
11. a. NPI/API Submitting Provider/Case Manager(For DD and CMHP waivers) /Transition Coordinator (for EDCD Waiver only). Name and Provider ID Number:										12. PA Service Type:														
b. 9 digit Zip Code (Required)										<input type="checkbox"/> 0902 – IFDDS Waiver <input type="checkbox"/> 0960 – Technology Assist <input type="checkbox"/> 0625 – Elderly Case Management <input type="checkbox"/> 0970 – Children’s Mental Health <input type="checkbox"/> 0900 – EDCD Waiver <input type="checkbox"/> 0920 – AIDS/HIV Waiver <input type="checkbox"/> 0909 – MFP Enrollment														
13. Justification/Need for Waiver Service Requested:																								
14. Additional Comments (See instructions pertaining to each procedure code):																								

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DMAS 98

Revised 7/16/2009



Community Based Care Request for Services Form

Enrollee Last Name:		Enrollee First Name:				Enrollee Medicaid ID Number:		
15. Procedure Code (National Code)	16. Narrative Description	17. Modifiers (if applicable)	18. Units/ Hrs Requested	19. Frequency	20. Actual Cost per Unit (if applicable)	21. Total Dollar Requested (If applicable)	22. Dates of Service	
							From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Contact Person:			24. Contact Phone Number:			25. Contact Fax Number:		

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INSTRUCTIONS FOR WAIVER ELECTRONIC FAX FORM

Web Resources: www.dmas.kepro.org
www.dmas.virginia.gov

This FAX submission form is required for Waiver enrollment, service requests, and prior authorization review.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via FAX for additional information. Do **not** send attachments or non-KePRO forms for service requests. For EDCD and HIV/AIDS Waiver enrollment requests only send pertinent documents needed for enrollment.

If KePRO determines that your request meets appropriate review guidelines the request will be “tentatively approved” and transmitted to First Health Services (FHS) for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS 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 ✓ or X in the appropriate box.
 - **New:** Use for all new requests. Resubmitting a request after receiving a reject would also be a new request.
 - **Change:** a change to a previously approved request; the provider may change the quantity of units, dollar amount approved or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders when required. **When a provider discontinues services, this is a change.** The provider may not submit a “change” request for any item that has been denied or is pending. Please also include the PA number you wish to change.
 - **Cancel:** Use only to cancel all or some of the items under one preauthorization number. Do not use for a discharge or discontinuance of services. An example of cancelling all lines is when an authorization is requested under the wrong enrollee number. Also, please include the PA number you are cancelling.
 - **Transfer:** Use for requests requesting a transfer of care or transfer of a provider number.
2. **Date of Request:** the date you are submitting the prior authorization request in MM/DD/YYYY format..
3. **Review Type:** Place a ✓ or X in the appropriate box. For retrospective eligibility or if the request is not submitted within 10 business days of the start of care, state the date the provider received verification of Medicaid eligibility (DMAS-122). The date the DMAS-122 is received is not required unless submitting a requesting more than 10 business days after the start of care and retroactive authorization is requested.
4. **Enrollee Medicaid ID Number:** It is the provider’s responsibility to ensure the enrollee’s Medicaid number is valid. This is a 12 digit number.
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.



Community Based Care Request for Services Form

7. **Date of Birth:** Date of birth is critically important and should be in the MM/DD/YYYY format (for example, 02/25/2004).
8. **Gender:** Please place a or **X** to indicate the sex of the patient.
9. a. **NPI/API/ Service Provider Name and Provider ID Number:** Enter the name of the provider who is providing the service and Provider ID number or national provider identifier (when the NPI is issued).
 b. **9 digit Zip Code (Required):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.
10. **Primary Diagnosis Code/Description: This is a required field.** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 ICD-9 codes and descriptions.
11. a. **NPI/API Submitting Provider/Case Manager/Transition Coordinator (For DD and CMHP waivers) Name and Provider ID Number:** Enter the submitting provider name and Provider ID number, national provider identifier or atypical provider identifier for the provider who is submitting request.
 b. **9 digit Zip Code (Required):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.
12. **PA Service Type:** Place a or **X** to indicate the category of service you are requesting.
13. **Justification/Need for Requested Waiver Service:** One of the most important blocks on the form is the need for waiver service. Knowledge of the DMAS criteria/guidelines will be helpful to provide pertinent information. Please refer to the service being requested and include the necessary information. **DO NOT ATTACH ASSESSMENTS, PLANS OF CARE, Etc**
14. **Additional Comments** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the regulations, DMAS manual, and criteria (see PA chapter in the DMAS manual).

TABLE OF CODES WITH NARRATIVE:

National Code /Modifier	Service Category/Description	Waiver
97139	Therapeutic Consultation: Justification/ Need must include objectives, outcomes and the activities conducted and the other waiver services received. Justification/ Need may NOT include direct therapy, nor duplicate activities available through the state plan. Justification/ Need cannot be solely for the purpose of monitoring.	DD, CMHP
97537	Day Support, Regular, Center or Non-Center Based: Justification/ Need must include the Day Support provider information defining the date, type of services rendered, goals and objectives and the number of hours and units provided.	DD
97537 U1	Day Support – High Intensity Center or Non Center Based:	DD

Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
99199 U4	<p>Environmental Modifications – Maintenance: Used when request is for maintenance to a previous approved and purchased item. Justification/ Need must include documentation of the name of at least one other qualifying waiver service.</p> <p>Beginning 7/1/09, EM can only be authorized for EDCD/AIDS when enrollee is dually enrolled in MFP – Service Type 0909</p> <p>DD Waiver and CMHP Waiver: Justification/ Need must include documentation for the description of the item, cost of materials, labor and must describe the direct medical and/ or remedial benefit to the individual.</p>	DD, CMHP, TECH and MFP
H0040	<p>Crisis Stabilization – Supervision: Justification/ Need must include documentation of the type of direct intervention and the type of serious psychiatric or behavioral problems.</p> <p>Justification/ Need must include documentation of the type of services conducted and the services occurred, the date of the face to face assessment conducted by a qualified professional and the name of the Crisis Stabilization provider.</p>	DD
H2011	<p>Crisis Stabilization- Intervention: See code H0040 of this table.</p>	DD
H2014	<p>In-home Residential Support: Justification/ Need must include documentation of the type of specialized supervision authorized, if and why staff presence is required to ensure ongoing or intermittent intervention to ensure the health and safety of the individual.</p> <p>Justification/ Need must include documentation of the need for specialized supervision and must include exactly what specialized supervision activities the staff will be performing to include the dates, times, amount and type of services provided.</p> <p>Justification/ Need must include documentation of services required must exceed supports provided by the family or other paid or non-paid caregivers.</p>	DD, CMHP
H2021 TD	<p>PERS Nursing – RN: DD Waiver: Justification/ Need must include documentation that there is no one else in the home that is competent or continuously available to call for help in an emergency.</p> <p>Justification/ Need must include documentation of the physician name and date for the physician ordered medication monitoring units and the name of at least one other billable waiver service being provided.</p> <p>EDCD and AIDS Waivers: Justification/ Need must include documentation that the individuals receiving PERS does not receive supervision on the personal care POC.</p> <p>Justification/ Need must include documentation of the recipients' cognitive level.</p> <p>Justification/ Need must include documentation of the recipients living alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time.</p> <p>Justification/ Need must include documentation of the physician name and date for the physician ordered medication monitoring units and the kind of other waiver billable services being provided.</p>	DD, EDCD, AIDS
H2021 TE	<p>PERS Nursing – LPN: DD Waiver: Justification/ Need must include documentation of services for individuals' when there is</p>	DD, EDCD, AIDS

Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
	<p>no one else in the home that is competent or continuously available to call for help in an emergency. Justification/ Need must include documentation of the name and date of the physician ordered medication monitoring units and the name of other billable waiver services being provided. Justification/ Need for Waiver Service must include provider documentation that the individuals receiving PERS does not receive companion care. EDCD and AIDS Waivers: Justification/ Need must include documentation that the individuals receiving PERS does not receive supervision on the personal care POC. Justification/ Need must include provider documentation of the recipients' cognitive level. Justification/ Need must include documentation of the recipients living alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time. Justification/ Need must include documentation of the physicians name and date for physician ordered medication monitoring units and the kind of other waiver billable services being provided..</p>	
H2023	<p>Supported Employment – Individual: Justification/ Need must include documentation of how the individuals required training will be accomplished. Training area must include specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to maintain paid employment. Justification/ Need must include documentation of which model is being provided: <u>Individual Supported Employment</u> (provided by a one to one job coach in order to work independently). <u>Group Supported Employment</u> (continuous support provided by staff to eight or fewer persons with disabilities). NOTE: This service, either as a stand alone service or in combination with prevocational and or Day Support services shall be limited to 780 units per CSP year.</p>	DD
H2024	<p>Supported Employment – Enclave: continuous support provided by staff to eight or more individuals in a work group. See Code H2023 in this table. NOTE: This service, either as a stand alone service or in combination with prevocational and or Day Support services shall be limited to 780 units per CSP year.</p>	DD
H2025	<p>Pre-Vocational Services, Regular Intensity: Justification/ Need must include documentation of the individuals need for preparation for paid or unpaid employment but are not job task oriented. Justification/ Need must include documentation of why the individual is not expected to join the general workforce without support, the type of support needed or participation in a transitional sheltered workshop within one year of beginning waiver services. Justification/ Need must include documentation of the date, type of services rendered and the number of hours and units provided. Documentation must not include activities primarily directed at teaching specific job skills but underlying rehabilitative goals such as: accepting supervision, attendance, task completion, and problem solving and safety. Justification/ Need must include documentation when the staff is required to ride to and from pre-vocational services the staff time can not exceed 25% of the total time spent in services for that day NOTE- This service, either as a stand- alone service or in combination with supported employment services shall be limited to 780 units per POC year.</p>	DD



Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
H2025 U1	Pre-Vocational Services, High Intensity See Code H2025 in this table.	DD
S5102	Adult Day Health Care: Justification/ Need must include documentation of the number of days per week and hours of ADHC services.	EDCD
S5111	Family Caregiver Training: Justification/ Need must include documentation of what the individual's family or caregivers training needs and how this training is necessary in order to improve the family or caregivers ability to provide care. Justification/ Need must include documentation of the name of at least one other billable IFDDS waiver service and the name of the individual being trained.	DD, CMHP
S5126	CD Personal Care CD/ Personal Assistance: EDCD and AIDS Waiver Justification/ Need must include documentation of the recipient's mental/cognitive status, and name of emergency back up person. The recipient's LOC from the DMAS 97A/B (if LOC C, the skilled nursing need must be documented, the type of services needed and the time of day it is provided, the total number of weekly hours requested where the services are performed and the first day the aide provided hands on care. The number of hours of supervision, documentation of the recipient's mental/cognitive status, ability to use the phone, no one present in the home to call for help and why it is needed. The name of the person directing the care and the name of the person providing the care. Who is with the recipient at all times when the aide is not present? The name of the services facilitator. For children in school, a statement that the services are not provided during school hours is required. DD Waiver Justification/ Need must include documentation of the recipient's age, mental/cognitive status, ability to use the phone, name of PCG, and name of emergency back up person. The recipient's LOC from the DMAS 97A/B the type of services needed and the time of day provided, the total number of weekly hours requested where the services are performed and the first day the aide provided hands on care. The number of hours of supervision, no one present in the home to call for help and why it is needed. The name of the Service Facilitator and the type of other billable waiver services received. NOTE: Training is not PC services. NOTE: All waivers- aides may not be the parents of minor children who are receiving waiver services or the spouse of the individuals who are receiving waiver services or the family/caregivers that are directing the individual's care.	AIDS, DD, EDCD
S5135	Companion Care: Justification/ Need must include documentation of the name of the PCG, name of the emergency back-up person. Justification/ Need must include documentation of how many individuals are sharing hours in the same home. Justification/ Need must include documentation of the mental/ orientation status of the individual, name of primary caregiver (PCG) and the hours the PCG works. Also needs to state the individual's ability/ inability to use the phone. Documentation needs to state if the individual is using a PERS device. Justification/ must include documentation of the number of hours per day and the type of services being rendered. Justification/ Need must include documentation of individual receiving continuous feeding tubes, require suctioning or on ventilators. Justification/ Need must include provider documentation of the type of clear and present danger if the individual is left unsupervised.	DD, CMHP



Community Based Care Request for Services Form

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	NOTE: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and or socialization.	
S5136	CD-Companion Care: See code S5135 in this table above and... Justification/ Need must include documentation of the name of the PCG, name of the individual directing the care and name of the emergency back-up person.	DD, CMHP
S5150	Consumer-Directed Respite Services: AIDS Waiver, DD Waiver and CMHP Waiver: Justification/ Need must include the name of the unpaid PCG <u>who resides in the same home</u> , the name of the individual directing the care and name of the emergency back-up person. EDCD Waiver: Justification/ Need must include documentation of the name of the unpaid PCG, the name of the individual directing the care, name of the emergency back-up person and where the care is provided.	EDCD, DD, AIDS, CMHP
S5160	PERS Installation: DD and EDCD Waiver: Must be requested with S5161	DD, EDCD, AIDS
S5160 U1	PERS Medication Monitoring Installation: Must be requested with S5185	EDCD, DD, AIDS
S5161	PERS Monitoring: DD Waiver: Justification/ Need must include documentation that there is no one else in the home that is competent or continuously available to call for help in an emergency and the name of at least one other billable waiver service being provided. Justification/ Need for Waiver Service must include provider documentation that the individuals receiving PERS does not receive companion care. AIDS, EDCD Waiver: Justification/ Need must include documentation of prior- installation of a PERS system or current request of installation, the name of at least one other billable waiver service, documentation that the individuals receiving PERS does not receive supervision on the personal care POC. Justification/ Need must include provider documentation of the recipients' cognitive level. Justification/ Need must include provider documentation of the recipients living alone or is alone for significant parts of the day and has no regular caregiver for extended periods of time.	EDCD, DD, AIDS
S5165	Environmental Modifications-DD, CMHP: Any request, change, increase, decrease and/or update must be pre- approved by DMAS on the CSP before prior authorization can occur. Justification/ Need must include documentation of the name of at least one other qualifying Waiver service. Beginning 7/1/09, EM can only be authorized for EDCD/AIDS when enrollee is dually enrolled in MFP – Service Type 0909 DD Waiver, CMHP: Justification/ Need must include documentation for the description of the item, cost of materials, labor and must describe the direct medical and/ or remedial benefit to the individual. For CMHP, EM may be provided to ensure safety of the recipient, caregivers, or community. Tech Waiver: Justification/ Need must include documentation for the description of the item, cost of materials, labor and must describe the direct medical benefit to the individual.	DD, Tech Waiver, CMHP, and MFP



Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
S5185	PERS and Medication Monitoring: See Code H2021 TE and H2021 TD in this table.	DD, EDCD, AIDS
S9125TD	Respite Services – RN: Justification/ Need must include documentation of the name of the unpaid PCG (<u>who resides in the same home for AIDS Waiver</u>) the name of the individual directing the care and name of the emergency back-up person. Justification/ Need must include documentation of the skilled nursing need (e.g. tube feedings, injections, etc.) Justification/ Need must include documentation of the physician name and date on the Respite Care Needs Assessment and Plan of Care (DMAS-300) Justification/ Need must include documentation of the types of skilled nursing service needs, the start of care date, the number of hours and where the services are provided.	AIDS EDCD
S9125TE	Respite Services – LPN: See code S9125TD in this table.	AIDS EDCD
T1002	Private Duty/Skilled Nursing – RN: AIDS and DD Waiver: Justification/ Need must include provider documentation of the type of serious medical condition and complex health care needs. Justification/ Need must include documentation of skilled nursing services ordered by a physician (DD Waiver must be pre-approved by DMAS on the CSP). Justification/ Need must include documentation of the physician’s signature and date found on the DMAS 485. <u>PA cannot occur before the Physician dated signature.</u> Justification/ Need must include documentation of the name and title of the nurse who will perform the skilled nursing services. (DD Waiver) AIDS Waiver: Justification/ Need must include documentation of less than 16 hrs/day for – this relates to shift work. Justification/ Need must include documentation for cases when 2 Waiver recipients share a residence, there shall be a maximum ratio of 1 PDN to 2 Waiver recipients. When three or more Waiver recipients share a residence, ratios will be determined by the combined needs of the recipients.	AIDS, DD
T1005	Agency Respite Care/Services: DD Waiver, AIDS Waiver and CMHP: Justification/ Need must include documentation of the name of the unpaid PCG <u>who resides in the same home</u> , the name of the individual directing the care, name of the emergency back-up person and where the care is provided. EDCD Waiver: Justification/ Need must include documentation of the name of the unpaid PCG, the name of the individual directing the care, name of the emergency back-up person and where the care is provided.	AIDS, DD, EDCD, CMHP
T1016	Case Management: Justification/ Need must include documentation of what other services are being provided. For ECM, A statement with goals and expected timeframes for completion must be included and the date the recipient signed the plan must be stated.	AIDS ECM

Community Based Care Request for Services Form

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T1019	<p>Personal Care: EDCD and AIDS Waiver Justification/ Need must include documentation of the recipient's mental/cognitive status, and name of emergency back up person. The recipient's LOC from the DMAS 97A/B (if LOC C, the skilled nursing need must be stated) the type of services needed and the time of day it is provided, the total number of weekly hours requested where the services are performed and the first day the aide provided hands on care. The number of hours of supervision, documentation of the recipient's mental/cognitive status, ability to use the phone, no one present in the home to call for help and why it is needed. Who is with the recipient at all times when the aide is not present? For children in school, a statement that the services are not provided during school hours is required.</p> <p>DD Waiver: Justification/ Need must include documentation of mental/cognitive status, ability to use the phone, name of PCG, and name of emergency back up person. The recipient's LOC from the DMAS 97A/B, the type of services needed and the time of day provided, the total number of weekly hours requested where the services are performed and the first day the aide provided hands on care. The number of hours of supervision, no one present in the home to call for help and why it is needed.</p> <p>NOTE: Training is not PC services.</p>	AIDS, DD, EDCD
T1999	<p>Assistive Technology Rehabilitation/ Off shelf item: DD Waiver: Any request, change, increase, decrease and/or update must be pre- approved by DMAS on the CSP before prior authorization can occur. Justification/ Need must include documentation item must be from a qualified professional and include the description of the item, cost of materials, labor and must provide direct medical and/or remedial benefit to the individual. Justification/ Need must include documentation of how/why the individual requires specialized equipment and supplies, devices, controls and appliances and how they will enable them to perform ADLs, or to communicate with the environment in which they live. Justification/ Need must include documentation of cost which is not carried over from one CSP year to another CSP year</p> <p>Beginning 7/1/09, AT can only be authorized for EDCD/AIDS when enrollee is dually enrolled in MFP – Service Type 0909</p> <p>DD, Tech Waiver: Justification/ Need must include documentation of the name of at least one other billable Waiver service.</p> <p>Tech Waiver: Justification/ Need must include documentation item must be from a qualified professional and include the description of the item, cost of materials, labor and must provide direct medical benefit to the individual. This cost can not be carried over from one calendar year to another calendar year.</p>	DD, Tech Waiver, and MFP
T1999 U5	<p>Assistive Technology Maintenance Cost: Used when request is for maintenance to a previous approved and purchased item. See code T1999 in this table.</p> <p>Beginning 7/1/09, AT can only be authorized for EDCD/AIDS when enrollee is dually enrolled in MFP – Service Type 0909</p>	DD, Tech Waiver, and MFP
H2015	Transition Coordination. To qualify under MFP, individual must be a resident of a NF	MFP, EDCD



Community Based Care Request for Services Form

National Code /Modifier	Service Category/Description	Waiver
	<p>or Long-Stay Hospital and must be enrolled in MFP. The maximum authorization for Transition Coordination while in a facility is 60 days. Once the individual has moved to the community, transition coordination may be requested/approved for a maximum of 12 additional months. For MFP enrollment, certify on the request the individual meets all MFP requirements.</p> <p>EDCD Waiver: Must be enrolled in EDCC Waiver</p> <p>The authorized begin date of H2015 must not be prior to the begin date of EDCC enrollment, when this service is being requested under EDCC, service type 0900 (recipient discharged from a NF or Long-Stay Hospital). H2015 may have already been authorized under MFP, service type 0909 while in the facility, this does not affect the authorization through EDCC.</p>	
T2038	<p>Transition Services. The Transition Coordinator or Case Manager must submit the request for transition services. Prior to discharge from the facility, Transition Services may be requested for individuals transitioning into EDCC or AIDS Waiver. DMAS processes DD Waiver requests prior to discharge. After discharge, the request for transition services must be submitted within 30 days of the NF/Long-Stay Hospital discharge date. Recipient must be enrolled in MFP or the specific Waiver and have been a resident of an NF for 6 months prior to waiver enrollment. DD Waiver must be approved by DMAS on the P.O.C.</p>	EDCC, AIDS, DD, and MFP

15. **Procedure Code:** Provide the HCPCS/CPT/Revenue/National procedure code (For example, T1019, S5135, etc.)
16. **Narrative Description:** Provide the HCPCS/CPT/Revenue/National procedure code description. (For example, Personal Care, Companion Care, etc.)
17. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. This applies only to specific Procedure Codes. See chart above. Example: Pre-Vocational Services, High Intensity, U1 is the modifier.
18. **Units/Hrs Requested:** Based on physician's orders or plan of care provide the number of units/hrs requested. Knowledge of DMAS criteria will be extremely helpful. How much of the service is being requested? Example: S5126, CD Personal Care, 30 hrs. The 30 hrs is the Units/Hrs requested
19. **Frequency:** Enter the frequency of the visits/service from the physician's order or plan of care. (day, week, biweekly {every other week}, month, year)
20. **Actual Cost per Unit (Assistive Technology or Environmental Mods Only):** Enter information in this column for codes identified as needing a cost per unit.
21. **Total Dollars Requested (Assistive Technology and Environmental Mods, Only):** If applicable, enter the dollar amount requested for items listed. All AT/EM codes combined can not exceed \$5,000.00 in a calendar year
22. **Dates of Service:** Indicate the planned service dates using the MM/DD/YYYY format. The From and Thru date must be completed even if they are the same date. If the request is open-ended, the Thru date may be 12/31/9999
23. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.
24. **Contact Phone Number:** Enter the phone number with area code of the provider contact name.



Community Based Care Request for Services Form

25. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject, a need to request additional information, insufficient (demographic) information, or to send a general provider letter via fax.

Note: Incomplete data may result in the request being rejected or denied; therefore, it is very important that this form be completed as thoroughly as possible with the pertinent 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.