NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

272INC FFS
07/2023

REQUEST FOR SERVICE AUTHORIZATION
FOR INCONTINENCE PRODUCTS
(Fee-for-Service (FFS) Program Only –
Not for Managed Care program use)

*****PLEASE PRINT OR TYPE ALL INFORMATION (All fields required)*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS (**NOT CODES**): _____
ALTERNATE INSURANCE: NAME OF PLAN: _____
Providers are expected to follow all third party payors requirements for payment and all third party obligations shall be exhausted before billing Medicaid, in accordance with 42 CFR 433.139.

PROVIDER INFORMATION

CONTACT PERSON: EMAIL:

TELEPHONE #: Ext: FAX #:

PROVIDER NAME: MEDICAID PROVIDER ID #:

INCONTINENCE PRODUCT(S) REQUESTED

Description of Product	Procedure Code and Modifier	Units/ mo.	Dates of Service		STATE USE ONLY
			Start Date of Service	End Date of Service	

CHANGE REQUEST FOR REVISIONS TO CURRENT AUTHORIZATIONS

Service Auth #: Reason for Change:

Description of Product	CPT Code		Units/ mo.	**Dates of Service**		STATE USE ONLY
	From	To		Start Date of Change	End Date of Change	

******* must be included with submission *******

DOCUMENTATION OF FACE TO FACE ENCOUNTER: Pursuant to He-W 571.05(h) A Provider shall conduct and document a face-to-face encounter with the recipient no earlier than 60 days prior to submitting a prior authorization request and the Provider's written order shall include the date of the encounter and the primary clinical reason the recipient needs the item(s).
PHYSICIAN'S ORDER: Pursuant to He-W 571.05 (a)(c)(d) a prescription shall be written by the NH licensed Provider including name, date of birth, address, Medicaid number and details of use of equipment.
LETTER OF MEDICAL NECESSITY: Pursuant to He-W 571.05(b)(c)(d) a signed letter of medical necessity shall be written by the NH licensed Provider for the requested DME, including name, date of birth, Medicaid number, a written diagnosis, anticipated length of use and supporting clinical documentation.

For the items listed above: I certify that I have obtained and attached a Face-to-Face documentation pursuant to He-W 571.05(h). I certify that I have attached a Physician's order and a LMN pursuant to He-W 571.05(d). I certify that products listed will be provided to the recipient.

Signature of Incontinence Product Provider Date Printed Name Title

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 314-8101