NEW HAMPSHIRE MEDICAID

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

Dates of Service: _____

EPSDT: _____SA #: _____

REQUEST FOR SERVICE AUTHORIZATION

FOR DURABLE MEDICAL EQUIPMENT (DME)

(**Fee-for-Service (FFS) Program Only** - Not for Managed Care program use)

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS 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: _____ PROVIDER MEDICAID ID #: _____

******* 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 Service 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 below requested DME, including name, date of birth, Medicaid number, a written diagnosis, anticipated length of use and supporting clinical documentation.

MOBILITY EVALUATION FORM AND NON-WHEELCHAIR EVALUATION FORM: Pursuant to He-W 571.05(c), requests for all wheelchairs, scooters, and customized strollers must also include a completed Form 272M, "Mobility Evaluation Form" Pursuant to He-W 571.05(e), requests for all standers, gait trainers, and bath and toileting items shall also include a completed Form 272EQ, "Medical Equipment Request Evaluation Form Non-Wheelchair," signed by all parties.

MSRP AND ACQUISITION COSTS PROOF: The manufacturer's quote or invoice with the MSRP and acquisition costs clearly defined.

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 DME Provider ***Date***

_____

Printed Name ***Title***

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

PLEASE LIST ALL DME PRODUCTS BEING REQUESTED ON PAGE 2

DME ORDERED

You must indicate all costs for each item listed. Use a separate form for additional items
****CLINICAL INFORMATION (must be included with submission):*****

ORDER INFORMATION									
Recipient Name:				**DOB:**		**Medicaid #:**			
Equipment Description	**Procedure Code**	**Modifier**	**# of Units**	**Acquisition Cost per unit**	**MSRP per unit**	**Monthly rental charge**	**Date(s) of Service**		**FOR STATE USE ONLY APPROVED AMOUNT**
							START	**END**	

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