

Instructions for Completion of BHSF Form 158-A

The Physician Outpatient Visit Extension Form, BHSF Form 158-A, is used by a physician to request approval for outpatient visits in excess of the 12 medically necessary visits allowed annually.

All items must be clearly written or typed.

Date: Enter the date this request is completed.

Identifying Information: The following items **must** be completed:

- Patient's name (recipient name as listed on the Health Network of Louisiana medical eligibility card)
- Patient's date of birth
- Patient's sex
- Patient's Medicaid Identification Number (complete 13-digit Medicaid identification number)
- Patient's Social Security Number (9 digits)

Specific Visits for Which Extension is Requested: Eleven (11) visits may be listed on each form. If approval for more than 11 visits is needed, additional form(s) must be completed.

The dates of visits for which approval is requested **must** be entered. **Only physician outpatient visits in excess of the 12 allowed annually are to be listed.** Visits deemed medically necessary are the only visits that will be considered for approval.

For each visit, the diagnosis code and Evaluation & Management (E&M) procedure code must be entered in the spaces provided. Documentation which supports the diagnosis and the reason for the visit must be attached. The documentation may include pathology or laboratory report(s), clinical notes, or a patient history.

Physician Identifying Information: The physician's name, address, and Medicaid ID (Vendor) number **must** be entered in the block provided. Within this space, the physician's name and address **must be printed clearly or typed**, to ensure proper identification and processing.

The form **must** be signed. Required signature must be the original signature of the physician or a stamped signature initialed by the physician or his authorized representative. Signature stamps alone or initials only are **not** acceptable.

Form submission: This form **must be submitted with documentation supporting the diagnosis and the reason for the visit**, to Molina at the address shown on the upper right-hand corner of this form. It will be returned to the treating physician when a decision is rendered.

A copy of the APPROVED Form 158-A must be attached to the hard copy claim(s) for these services in order for the claim(s) to be considered for payment.

Molina for
Louisiana's Medicaid Program
P.O. Box 14919
Baton Rouge, LA 70898-4919

PHYSICIAN OUTPATIENT VISIT EXTENSION FORM

I. TREATING PHYSICIAN – Complete this Section:

_____ **Date**

Approval of additional medically necessary physician outpatient visits is being requested for:

_____ **Patient's Name**

_____ **DOB**

_____ **Sex**

_____ **Medicaid Identification Number**

_____ **Social Security Number**

Provide a specific Diagnosis Code and Evaluation & Management (E&M) procedure code for each medically necessary visit extension request.

Attach documentation supporting the medical necessity of the request. (Pathology report, clinical note, etc.)

1. _____ / _____
Date of visit Diagnosis E&M

8. _____ / _____
Date of Visit Diagnosis E&M

2. _____ / _____
Date of visit Diagnosis E&M

9. _____ / _____
Date of visit Diagnosis E&M

3. _____ / _____
Date of visit Diagnosis E&M

10. _____ / _____
Date of visit Diagnosis E&M

4. _____ / _____
Date of visit Diagnosis E&M

11. _____ / _____
Date of visit Diagnosis E&M

5. _____ / _____
Date of visit Diagnosis E&M

Physician's Name, Address & Vendor No:

6. _____ / _____
Date of visit Diagnosis E&M

7. _____ / _____
Date of visit Diagnosis E&M

Signature of Treating Physician

II. MOLINA – Prior Authorization Unit Use Only

Physician outpatient visits approved for the following dates of service: _____

Extension(s) not approved for dates of service: _____

Rationale: _____

_____ **Date**

_____ **Signature of Reviewing Physician**