STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH
Bureau of Health Services Financing
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

GAINWELL TECHNOLOGIES/
LA Medicaid
FAX TO: (225) 216-6481

CONTINUATION OF SERVICES _____YES _____ NO

PRIOR AUTHORIZATION TYPE: (1)

___ 05 Rehabilitation Therapy

___ 09 DME Equipment & Supplies

____99 Specialized CPT Procedures Requiring Prior Authorization

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME FIRST MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)

PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(12)
PLACE OF TREATMENT: ____ RECIPIENT'S HOME ___ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

(13)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIPCODE _____

TELEPHONE: (_____) _____ _____ FAX NUMBER: (_____) _____ _____

COMMENTS:

(14)
PROVIDER SIGNATURE: _____

(15)
DATE OF REQUEST: _____

PA-01 FORM

Instructions For Completing Prior Authorization Form (PA-01)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

FIELD NO. 1 CHECK THE APPROPRIATE BLOCK TO INDICATE THE TYPE OF PRIOR AUTHORIZATION REQUESTED.

FIELD NO. 2 ENTER RECIPIENT'S 13-DIGIT MEDICAID ID NUMBER.

FIELD NO. 3 ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER.

FIELD NO. 4 ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THEIR MEDICAID CARD.

FIELD NO. 5 ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER. IF ASSOCIATED WITH A GROUP, ENTER THE ATTENDING PROVIDER NUMBER ONLY.

FIELD NO. 7 ENTER THE BEGINNING AND ENDING DATES OF SERVICE IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 8 ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.

FIELD NO. 9 ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 10 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES.

FIELD NO. 11 ENTER THE HCPCS CODE.

FIELD NO. 11A ENTER THE CORRESPONDING MODIFIERS (WHEN APPROPRIATE).

FIELD NO. 11B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED.

FIELD NO. 11C ENTER THE NUMBER OF UNITS REQUESTED FOR EACH INDIVIDUAL PROCEDURE.

FIELD NO. 11D ENTER THE REQUESTED CHARGES FOR EACH INDIVIDUAL PROCEDURE YOU ENTERED WHEN IT IS APPROPRIATE FOR THE REQUESTED PROCEDURE.

FIELD NO. 12 ENTER THE LOCATION FOR ALL SERVICES RENDERED.

FIELD NO. 13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE.

FIELD NO. 14 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO. 15 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS:

PRIOR AUTHORIZATION TOLL-FREE NO. IS 1-800-488-6334

PRIOR AUTHORIZATION UNIT NO IS 225-928-5263

PRIOR AUTHORIZATION FAX NO. IS 1-225-216-6481