STATE OF LOUISIANA
DEPARTMENT OF HEALTH
Bureau of Health Services Financing Medical Assistance Program

BATON ROUGE, LA. 70898-4919 REQUEST FOR PRIOR AUTHORIZATION P.A. NUMBER

FAX TO: (225) 216-6481 CONTINUATION OF SERVICES ____YES ____NO

(1) PRIOR AUTHORIZATION TYPE:	(2) BENEFICIARY 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	(4) BENEFICIARY LAST NAME FIRST NAME MI	(5) DATE OF BIRTH

(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY) END DATE (MMDDYYY)	(8)IS BENEFICIARY CURRENTLY RECEIVING THESE SERVICES ____YES ____NO	PRACTITIONER REVIEWER'S SIGNATURE & DATE

(9) DIAGNOSIS:
PRIMARY CODE

SECONDARY CODE

(10) PRESCRIPTION DATE (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

(11) PRESCRIBING PRACTITIONER'S NAME AND/ OR NUMBER:

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE	MODIFER	PERSONAL CARE SERVICE EACH 15 MINUTES	REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(13) PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

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

Comments:

(14)
PROVIDER SIGNATURE: _____

(15)
DATE OF REQUEST: _____

Revised PA-14 FORM
Revised 5/2019

Instructions for Completing Prior Authorization Form (PA-14)

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 DXC.

FIELD NO. 2 ENTER BENEFICIARY'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.

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

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

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

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER.

FIELD NO. 7 ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR.

FIELD NO. 8 PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE BENEFICIARY IS CURRENTLY RECEIVING SERVICES.

FIELD NO. 9 ENTER THE DIAGNOSIS CODES (PRIMARY & SECONDARY).

FIELD NO. 10 ENTER THE DAY THE PRESCRIPTION, PRACTITIONER'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 11 ENTER THE NAME OF THE BENEFICIARY'S ATTENDING PRACTITIONER PRESCRIBING THE SERVICES.

FIELD NO. 12 ENTER THE HCPCS CODE.

FIELD NO. 12A ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE).

FIELD NO. 12B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED. FIELD NO.

12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (1 UNIT = 15 MINUTES) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS COVERED IN THE TREATMENT PLAN. THIS WILL GIVE THE TOTAL UNITS REQUESTED. BELOW ARE TWO EXAMPLES ON THE PROPER WAY TO CALCULATE THE TOTAL UNITS REQUESTED:

EXAMPLE 1) REQUESTING FOUR-HOURS PER DAY FOR A SIX MONTH PERIOD:

4 HOURS PER DAY = 16 UNITS PER DAY, 7 DAYS A WEEK, 26 WEEKS =
16 X 7 X 26 = 2912 TOTAL UNITS REQUESTED

EXAMPLE 2) REQUESTING TWO-HOURS PER DAY ON WEEKENDS AND FOUR-HOURS PER DAY ON WEEKDAYS:

2 HOURS PER DAY (WEEKENDS) = 8 UNITS PER DAY, 2 DAYS A WEEK, 26 WEEKS =
8 X 2 X 26 = 416 TOTAL UNITS REQUESTED FOR WEEKENDS

4 HRS. PER DAY (WEEKDAYS) = 16 UNITS PER DAY, 5 DAYS A WEEK, 26 WEEKS =
16 X 5 X 26 = 2080 TOTAL UNITS REQUESTED FOR WEEKDAYS

THE TOTAL UNITS REQUESTED WOULD BE THE COMBINATION OF THE TOTAL WEEKEND UNITS (416) AND WEEKDAY UNITS (2080), WHICH WOULD EQUAL TO 2496 TOTAL UNITS REQUESTED. THIS IS THE NUMBER (2496) TO ENTER IN FIELD NUMBER 12C.

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 DXC.

PRIOR AUTHORIZATION PCS DEPARTMENT TOLL-FREE NO. IS 1-800-807-1320

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