MAIL TO:
DXC/ LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

REQUEST FOR PRIOR AUTHORIZATION

PRIOR AUTHORIZATION NUMBER

PRIOR AUTHORIZATION TYPE 07- AIR AMBULANCE	(1) RECIPIENT 13-THIRTEEN DIGIT MEDICAID NUMBER OR 16-SIXTEEN DIGIT CCN NUMBER / / / / / / / / / / / / / / /	(2) DATE OF BIRTH / /

7-DIGIT MEDICAID PROVIDER NUMBER (3) / / / / / /	RECIPIENT LAST NAME (4) FIRST	(5) DATES OF SERVICE FROM THRU

DIAGNOSIS PRIMARY CODE AND DESCRIPTION (6)	STATUS CODES: 2 = APPROVED 3 = DENY
DESCRIPTION OF SERVICES	P.A REVIEWER SIGNATURE: & DATE

PROCEDURE CODE	DESCRIPTION	(UNITS) MILEAGE ONE WAY	STATUS	P.A ERROR CODE(S)	
(7)	(7)	(8)			

PROVIDER NAME & ADDRESS: (9)	CONTACT PERSON : (10)
	TELEPHONE NUMBER: ( )
	COMMENTS:

PROVIDER SIGNATURE: _____(11)_____ SIGNATURE DATE: ___(11)_____ **(PA- 15) Form**

INSTRUCTIONS FOR COMPLETING PRIOR AUTHORIZATION FORM (PA-15)

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. 1: Enter the recipient's 13-digit Medicaid ID number or the 16-digit CCN number

FIELD NO. 2: Enter the recipient's date of birth in month, day, year format(MMDDYYYY).

FIELD NO. 3: Enter your 7-digit Medicaid provider number

FIELD NO. 4: Enter the recipient's last name and first name as it appears on their Medicaid identification card.

FIELD NO. 5: Enter the from and through dates of service in month, day, year format(MMDDYYYY).

FIELD NO. 6: Enter the numeric primary diagnosis code and corresponding description.

In emergency cases this may be obtained from emergency room staff members.

In non-emergency cases, this may be obtained from the referring provider.

FIELD NO. 7: Enter the appropriate 5-digit procedure code and it's corresponding description. The following procedure codes are the only ones that can be used on this form:

A0430 - Fixed Wing Air Transport
A0431 - Rotary Wing Air Transport
A0435 - Fixed wing air mileage
A0436 - Helicopter air mileage

FIELD NO. 8: Enter the total number of unit(s) (mileage one way) for each procedure code listed. (Base rate air ambulance procedure will be equal to 1-one unit).

FIELD NO. 9: Must have the name and complete address of the servicing provider.

FIELD NO.10: Must have the name of a contact person at the servicing provider office and a telephone number.

FIELD NO.11: The provider must sign and date the prior authorization request.

REMINDER:

Providers must send the medical records, and any other information as previously, to justify the medical necessity of the air transportation.

The origin and destination of the flight must be part of the information sent with the request.