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

P.A. NUMBER

FAX TO: (225) 216-6342 **CONTINUATION OF SERVICES _____YES _____ NO**

(1) PRIOR AUTHORIZATION TYPE:	(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
16– PEDIATRIC DAY HEALTH CARE SERVICES	(4) RECIPIENT 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 RECIPIENT CURRENTLY RECEIVING THESE SERVICES _____ YES _____ NO

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

(9) DIAGNOSIS:
PRIMARY CODE

SECONDARY CODE

(10) PHYSICIAN'S ORDER DATE (MMDDYYYY)

STATUS CODE:
2= APPROVED
3= DENIED

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

DESCRIPTION OF SERVICES | **FOR INTERNAL USE ONLY**

(12) PROCEDURE CODE	(12A) MODIFER	(12B) DESCRIPTION PEDIATRIC DAY HEALTH CARE SERVICES	(12C) REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)

(13) Brief Medical History:

(14) **Current Status:**

(15) **Physician's orders/treatment Plan (Provide Frequency, Duration, and Provider Type for services requested:**

(16)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____**ZIPCODE** _____

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

(17) CASE MANAGER INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____**STATE:** _____**ZIPCODE:** _____

TELEPHONE: (____) _____ _____ FAXNUMBER: (____) _____ _____

(18)
PROVIDER SIGNATURE: _____

(19)
DATE OF REQUEST: _____

Revised PA-16 Form
Issued 10/1/2015

Instructions for Completing Prior Authorization Form (PA-16)

Note: Only the field list below is 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 **Recipient Medicaid ID - Enter the 13 digit Medicaid ID number or The 16 Digit CCN Number.**

FIELD NO 3 **Social Security Number - Enter the recipient's social security number.**

FIELD NO 4 **Recipient Name – Enter recipient's last name, first name, and middle initial**

FIELD NO 5 **Date of Birth – Enter recipient's date of birth in MMDDYYYY Format (MM=Month, DD=Day, YYYY=Year).**

FIELD NO 6 **Medicaid Provider Number - Enter the 7 digit assigned to you by Medicaid**

FIELD NO 7 **Service Treatment Plan – This identifies the period covered by the Plan of Care. Enter the dates in MMDDYYYY Format (MM=Month, DD=Day, YYYY=Year).**

FIELD NO 8 **Is Recipient currently receiving these services? Place a checkmark in the 'Yes' or 'No' Box to indicate whether or not the recipient is currently receiving services.**

FIELD NO 9 **Diagnosis – <u>Primary Code</u>. Enter a valid diagnosis code and condition which best describes the principal reason for Pediatric Day Health Care. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.**
Diagnosis – <u>Secondary Code</u>. Enter a valid diagnosis code and condition relevant to the care rendered. Place in order of seriousness to justify the discipline and services being rendered. Other pertinent diagnoses are conditions that coexisted at the time the plan of care was established or developed subsequently.

FIELD NO 10 **Physician's Order Date – Enter the date the Physician's Order was written in MMDDYYYY Format (MM=Month, DD=Day, YYYY=Year).**

FIELD NO 11 **Prescribing Physician's Name and/or Number – Enter the name of the recipient's attending physician prescribing the services and the physician's NPI number.**

FIELD NO 12 **Procedure Code – Enter the HCPCS Code.**

FIELD NO 12A **Modifier – Enter the corresponding modifier (when appropriate).**

FIELD NO 12B **Description – Enter the HCPCS code's corresponding description for each procedure requested**

FIELD NO 12C **Requested Units - Reimbursement for PDHC services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified recipient attends the PDHC facility.**
<u>For Full Day of Service, the Procedure Code T 1025</u> will be used for more than four hours but doesn't exceed 12 hours per day. Calculate the total units requested by multiplying the full day per diem by the number of days per week times the number of weeks covered in the treatment plan. This will give the total units requested.
***Example- Procedure Code T 1025* - 1 full day of service X 7 days a week x 26 weeks = 182 units requested.**
<u>For a Partial Day of Service, the Procedure Code T 1026</u> will be used for services four hours or less per day, Calculate the total units requested by multiplying the number of hours per day by the number of days per week times the number of weeks covered in the treatment plan. This will give the total units requested.
***Example - Procedure Code T 1026* - 4 hours per day x 7 days a week x 26 week = 728 units requested.**

FIELD NO 13 **<u>Brief Medical History</u> – Provide a brief summary of recipient's medical history that best describes the need for PDHC.**

FIELD NO 14 **<u>Current Status</u> –Describe recipient's current medical status (examples -chronic, remission, stable, etc.)**

FIELD NO 15 **<u>Physician's orders/treatment Plan</u> – Provide the Frequency, Duration, and Provider Type for services requested.**

FIELD NO 16 **Provider Name – Enter the name, mailing address, telephone and fax number of the Provider of Service.**

FIELD NO 17 **Case Manager Information – Enter the name, mailing address, telephone and fax number of Case Manager.**

FIELD NO 18 **Provider Signatures - 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 19 **Date of Request – The date is required and 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 PDHC Department Toll Free Number is 1-800-807-1320.
Prior Authorization Fax Number is 1-225-216-6342.