INSTRUCTIONS FOR COMPLETING THE PRE-CERT REQUEST FORM P.C.F01
Please note that ALL FIELDS ARE REQUIRED. Incomplete forms will result in a REQUEST REJECTION.

1. Enter the case number when requesting extension of days, or reconsideration. Leave this field blank when requesting an initial admission review.

2. Enter the type of facility requesting admission approval and LOS assignment.

3. Check the appropriate box to indicate the type of review requested. If extension request, please indicate extension number. Reconsideration to be checked for cases denied for medical necessity. For resubmittals, follow instructions as documented on rejection letter. **Update is used for adding recipient Medicaid ID number for newborns and/or outpatient procedures performed on an in-patient basis if it is primary or only procedure preformed within the first two days of the hospital stay.** It is not necessary to update other procedures. Retrospective is for recipients discharged from hospital when positive determination of Medicaid eligibility could not be made during admission process.

4. Enter one of the following LEVEL-OF-CARE or UNIT-OF-CARE CODES:

BURN	Burn Unit	**PICU**	Pediatric Intensive Care Unit
CCU	Coronary Care Unit	**PSYCH**	Psychiatric Unit
GEN	General Unit	**REHAB**	Rehabilitation Unit
ICU	Intensive Care Unit	**SAU**	Substance Abuse Unit
NICU	Neonatal Intensive Care Unit	**TU**	Telemetry Unit
OU	Observation Unit	**LT**	Long Term

5. Enter the 13-digit recipient's Medicaid number.

6. Enter the recipient's age on date of admit. If recipient is less than 1 year old, enter zeros in this field.

7. Enter the recipient sex. M=male F=female

8. Enter the recipient date of birth MM/DD/YY.

9. Enter a "Y" in this field if the recipient is eligible for Medicare Part-A and benefits have expired. If used, a Medicare EOMB or other appropriate documentation must be attached to this form.

10. Enter the recipient's last name, first name, and middle initial.

11. Enter the seven-digit Hospital Medicaid number.

12. Enter the name of the person to be contacted for information pertaining to this case.

13. Enter the phone number for the contact on this case.

14. Enter the fax number where data should be faxed, if desired.

15. Enter the admitting/attending physician Medicaid number of the primary care physician. If the physician is not enrolled in the Medicaid program, leave blank.

16. Enter the admission date MM/DD/YY. If the actual date is not know, enter the anticipated admit date. Enter the admission time (in military format).

17. Enter the date of discharge for retrospective review cases only, where the recipient has already been discharged.

18. If the recipient is being transferred from another facility, or a separate unit in the same facility, enter the transferring facility's Medicaid ID number (if Medicaid enrolled). If not enrolled in Medicaid, enter that facility's name. If not a transfer, leave blank.

19. For an initial admission, enter the ADMITTING (most likely the initial diagnosis; may be problem oriented), PRIMARY (more specific or final disposition based on hospital diagnostic testing), and OTHER diagnosis ICD-9-CM codes and descriptions that pertain to the recipient's condition. **You must enter at least the admitting and/or the primary diagnosis. For extension requests, you must enter an extension diagnosis.**

20. Enter the date of surgery if applicable to this case (required for organ transplants and outpatient surgery performed on an inpatient basis).

21. Enter the procedure(s) ICD-9-CM codes associated with this case (required for organ transplants and outpatient surgery performed on an inpatient basis, for which you must also submit for PCF02).

22. **Authorized signature is required. Requests will not be accepted if not signed.**

23. Enter the date this request is submitted to Molina.

24. Enter the time of day (military time format) this request is submitted to Molina.

Mail to: Molina Louisiana Medicaid
Hospital Pre-Certification Program
Post Office Box 14849
Baton Rouge, LA 70898-4849

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

REQUEST FOR HOSPITAL PRE-ADMISSION CERTIFICATION AND LOS ASSIGNMENT

Phone: 1-800-877-0666
Fax: 1-800-717-4329

NOTE: This form must be completed in full to be considered for review by Molina.

(1) **PRE-CERT CASE NUMBER** ☐☐☐☐☐☐☐☐☐

(2) **TYPE:** ☐☐

01 DISTINCT PART PSYCH (PRE-ADMISSION/LOS REVIEW)
02 LONG TERM HOSPITAL (PRE-ADMISSION/LOS REVIEW)
03 ACUTE CARE (MED-SURG)/REHAB (LOS REVIEW ONLY)
04 FREE-STANDING PSYCH (PRE-ADMISSION/LOS REVIEW)

☐ **INITIAL REQUEST**
☐ **LOS EXTENSION REQUEST**
☐ **EXTENSION NUMBER** (3)
☐ **RECONSIDERATION REQUEST**
☐ **RESUBMITTAL**
☐ **UPD ATE**
☐ **RETRO SPECTIVE**

(4) **LEVEL OF CARE/UNIT OF CARE:** ☐☐☐☐☐

(5) **RECIPIENT MEDICAID ID** ☐☐☐☐☐☐☐☐☐☐☐☐☐ (6) **AGE** ☐☐☐ (7) **SEX** ☐

(8) **DATE OF BIRTH** ☐☐/☐☐/☐☐ (9) **MEDICARE PART-A BENEFITS EXHAUSTED** ☐

(10) **RECIP LAST NAME** ☐☐☐☐☐☐☐☐☐☐☐☐☐ **FIRST** ☐☐☐☐☐☐☐ **MI** ☐

(11) **HOSPITAL MEDICAID ID** ☐☐☐☐☐☐☐

(12) **HOSPITAL CONTACT PERSON** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(13) **PHONE** ☐☐☐ ☐☐☐☐☐☐☐ (14) **FAX** ☐☐☐ ☐☐☐☐☐☐☐

(15) **ATTENDING PHYSICIAN MEDICAID ID (if Medicaid enrolled)** ☐☐☐☐☐☐☐

(16) **ADMISSION DATE AND TIME (actual/anticipated)** ☐☐/☐☐/☐☐ **(MILITARY TIME)** ☐☐ : ☐☐

(17) **DISCHARGE DATE (FOR RETROSPECTIVE REVIEWS ONLY)** ☐☐/☐☐/☐☐

IF THIS IS A TRANSFER FROM ANOTHER FACILITY, ENTER THE TRANSFERRING FACILITY MEDICAID ID OR FACILITY NAME BELOW

(18) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(19)

	AGNOSIS (ICD-9-CM)	DESCRIPTION
AD MITTING	☐☐☐☐☐	
PRIMARY	☐☐☐☐☐	
OTHER	☐☐☐☐☐	
	☐☐☐☐☐	
	☐☐☐☐☐	
EXTENSION	☐☐☐☐☐	

(20) **SURGERY DATE** ☐☐/☐☐/☐☐

(21) **PROCEDURE CODE(S) (ICD-9-CM)** ☐☐☐☐☐ ☐☐☐☐☐ ☐☐☐☐☐
☐☐☐☐☐ ☐☐☐☐☐ ☐☐☐☐☐

Note: If the primary procedure above is an outpatient surgical procedure performed within the first 2 days of the stay, you must submit for PCF02 with this form.

I certify that all information given is accurate and complete and I understand that any incomplete or inaccurate data may result in certification denial.

(22) **UTHORIZED SIGNATURE**______________________________

(23) **REQUEST DATE AND TIME** ☐☐/☐☐/☐☐ (24) **(MILITARY TIME)** ☐☐ : ☐☐

P.C. F01
ISSUED 3/95

Mail to: Molina Louisiana Medicaid
Hospital Pre-Certification Program
Post Office Box 14849
Baton Rouge, LA 70898-4849

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

REQUEST FOR HOSPITAL PRE-ADMISSION CERTIFICATION AND LOS ASSIGNMENT

Phone: 1-800-877-0666
Fax: 1-800-717-4329
NOTE: This form must be completed in full to be considered for review by Molina.

PRE-CERT CASE NUMBER ☐☐☐☐☐☐☐☐☐

TYPE: ☐☐

01 DISTINCT PART PSYCH (PRE-ADMISSION/LOS REVIEW)
02 LONG TERM HOSPITAL (PRE-ADMISSION/LOS REVIEW)
03 ACUTE CARE (MED-SURG)/REHAB (LOS REVIEW ONLY)
04 FREE-STANDING PSYCH (PRE-ADMISSION/LOS REVIEW)

LEVEL OF CARE/UNIT OF CARE: ☐☐☐☐☐

☐ **INITIAL REQUEST**
☐ **LOS EXTENSION REQUEST**
☐ **EXTENSION NUMBER**
☐ **RECONSIDERATION REQUEST**
☐ **RESUBMITTAL**
☐ **UPD ATE**
☐ **RETRO SPECTIVE**

RECIPIENT MEDICAID ID ☐☐☐☐☐☐☐☐☐☐☐☐☐ **AGE** ☐☐☐ **SEX** ☐

DATE OF BIRTH ☐☐/☐☐/☐☐ **MEDICARE PART-A BENEFITS EXHAUSTED** ☐

RECIP LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐ **FIRST** ☐☐☐☐☐☐☐ **MI** ☐

HOSPITAL MEDICAID ID ☐☐☐☐☐☐☐
HOSPITAL CONTACT PERSON ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
PHONE ☐☐☐ ☐☐☐☐☐☐☐ **FAX** ☐☐☐ ☐☐☐☐☐☐☐
ATTENDING PHYSICIAN MEDICAID ID (if Medicaid enrolled) ☐☐☐☐☐☐☐
ADMISSION DATE AND TIME (actual/anticipated) ☐☐/☐☐/☐☐ **(MILITARY TIME)** ☐☐ : ☐☐
DISCHARGE DATE (FOR RETROSPECTIVE REVIEWS ONLY) ☐☐/☐☐/☐☐

IF THIS IS A TRANSFER FROM ANOTHER FACILITY, ENTER THE TRANSFERRING FACILITY MEDICAID ID OR FACILITY NAME BELOW
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

DI AGNOSIS (ICD-9-CM)		**DESCRIPTION**
AD MITTING	☐☐☐☐☐	
PRIMARY	☐☐☐☐☐	
OTHER	☐☐☐☐☐	
	☐☐☐☐☐	
	☐☐☐☐☐	
EXTENSION	☐☐☐☐☐	

SURGERY DATE ☐☐/☐☐/☐☐

PROCEDURE CODE(S) (ICD-9-CM) ☐☐☐☐☐ ☐☐☐☐☐ ☐☐☐☐☐
☐☐☐☐☐ ☐☐☐☐☐ ☐☐☐☐☐

Note: If the primary procedure above is an outpatient surgical procedure performed within the first 2 days of the stay, you must submit for PCF02 with this form.

I certify that all information given is accurate and complete and I understand that any incomplete or inaccurate data may result in certification denial.
AUTHORIZED SIGNATURE____________________________________

REQUEST DATE AND TIME ☐☐/☐☐/☐☐ **(MILITARY TIME)** ☐☐ : ☐☐

P.C. F01
ISSUED 3/95