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**

PRIOR AUTHORIZATION TYPE: (1)	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)	Social Security No. (3)
06 - Home Health Services	RECIPIENT LAST NAME FIRST MI (4)	DATE OF BIRTH (5)
MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	SERVICE TREATMENT PLAN (7) BEGIN DATE (MMDDYYYY) / END DATE (MMDDYYYY)	IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8) _____ YES _____ NO
DIAGNOSIS : (9) PRIMARY CODE / SECONDARY CODE	PRESCRIPTION DATE (10) (MMDDYYYY)	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE
	PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:	STATUS CODES: 2 = APPROVED 3 = DENIED

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	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(12)

PROVIDER NAME: _____

ADDRESS: _____

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

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

COMMENTS:

(13)
PROVIDER SIGNATURE: _____

(14)
DATE OF REQUEST: _____

Revised PA-07 Form
Issued 10/1/2015

Instructions For Completing Prior Authorization Form (PA-07)

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 RECIPIENT'S 13 DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN 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 RECIPIENT'S 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

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 RECIPIENT IS CURRENTLY RECEIVING SERVICES

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

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

FIELD NO.11 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES

FIELD NO.12 ENTER 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 (4 UNITS = 1 HOUR) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS REQUESTED (TAKEN FROM THE SERVICES TREATMENT DATES (FIELD NO. 7 ABOVE). THIS WILL GIVE THE TOTAL UNITS REQUESTED.

EXAMPLE : 11 HOURS PER DAY , 7 DAYS PER WEEK, 26 WEEKS =

11 X 4 = 44 X 7 X 26 WEEKS = 8, 008

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 THIS FIELD IS NOT DATED

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

HOME HEALTH TOLL-FREE NO. IS 1-800-807-1320

HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225- 237-3342