MAIL TO:
MOLINA / 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) 929-6803

CONTINUATION OF SERVICES _____YES _____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
X 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2): 7777000011112222

Social Security No. (3):

RECIPIENT LAST NAME: Carabella **FIRST**: Travis **MI** (4):

DATE OF BIRTH (5):

MEDICAID PROVIDER NUMBER (7- DIGIT) (6): 1111113

BEGIN DATE OF SERVICE (MMDDYYYY) (7):

END DATE OF SERVICE (MMDDYYYY):

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION: CHF
SECONDARY CODE & DESCRIPTION:

PRESCRIPTION DATE (9) **(MMDDYYYY)**: 10 01 2015

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10):

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	ENTER NDC CODE (11 DIGITS) THAT CORRESPONDS WITH HCPC FORMULA CODE OR ENTER THE DESCRIPTION OF EACH PROCEDURE CODE (11B)	REQUESTED UNITS (11C)	REQUESTED AMT (11D)	AUTHORIZED UNITS	AUTHORIZED AMT	PA CODE(S)
A4927				Catheters				1231.20	
A4351				Non-Sterile Gloves	6				
A4402				Ostomy Lubricant				6.36	

(12)
PLACE OF TREATMENT: ____ RECIPIENT'S HOME ___ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: The Best DME Agency
ADDRESS: 111 Main Street
CITY: Solomon **STATE** LA **ZIPCODE** 00000
TELEPHONE: (___**)** ____ ____ **FAX NUMBER: (**___**)** ___ _____

(14) CASE MANAGER INFORMATION:
NAME: Carla Scott
ADDRESS: 1234 State Street
CITY: Baton Rouge **STATE;** LA **ZIPCODE** 00000
TELEPHONE (____**)** ____ _____ **FAX NUMBER: (**____**)** ____ _____

(15)
PROVIDER SIGNATURE: Connie David

(16)
DATE OF REQUEST: 10/01/2015

PA-01 FORM

Instructions for Completing Prior Authorization Form (PA-01)

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 UNISYS.

FIELD NO. 1 CHECK THE APPROPRIATE BLOCK TO INDICATE THE TYPE OF PRIOR AUTHORIZATION REQUESTED.

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 THEIR 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. IF ASSOCIATED WITH A GROUP, ENTER THE ATTENDING PROVIDER NUMBER ONLY.

FIELD NO. 7 ENTER THE BEGINNING AND ENDING DATES OF SERVICE IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 8 ENTER THE PRIMARY AND SECONDARY DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.

FIELD NO. 9 ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 10 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES.

FIELD NO. 11 ENTER THE HCPCS / PROCEDURE CODE.

FIELD NO. 11A ENTER THE CORRESPONDING MODIFIERS (WHEN APPROPRIATE).

FIELD NO. 11B ENTER THE 11 DIGIT NDC CODE THAT CORRESPONDS WITH THE HCPC FORMULA CODE, OR THE CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED.

FIELD NO. 11C ENTER THE NUMBER OF UNITS REQUESTED FOR EACH INDIVIDUAL HCPC/ PROCEDURE.

FIELD NO. 11D ENTER THE REQUESTED CHARGES FOR EACH INDIVIDUAL HCPC/ PROCEDURE WHEN APPROPRIATE FOR THE REQUESTED HCPC/ PROCEDURE.

FIELD NO. 12 ENTER THE LOCATION FOR ALL SERVICES RENDERED.

FIELD NO. 13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE.

FIELD NO. 14 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE RECIPIENT'S CASE MANAGER , IF AVAILABLE

FIELD NO. 15 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. 16 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 UNISYS:

PRIOR AUTHORIZATION TOLL-FREE NO.: 1-800-488-6334

PRIOR AUTHORIZATION UNIT NO.: 1- 225-928-5263

PRIOR AUTHORIZATION FAX NO.: 1-225-929-6803