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**
___ **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)

Social Security No. (3)

RECIPIENT LAST NAME **FIRST** **MI** (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (7) (MMDDYYYY)

END DATE OF SERVICE (MMDDYYYY)

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

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) **(MMDDYYYY)**

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 N**DC CODE (11** DIGITS) THAT CORRESPONDS WITH HCPC FORMULA CODE OR ENTER THE DESCRIPTION OF EACH PROCEDURE CODE (11B)	**REQUESTED** **UNITS** (11C)	**AMT** (11D)	**AUTHORIZED** **UNITS**	**AMT**	PA CODE(S)

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

(13)

PROVIDER NAME: _____

ADDRESS: _____

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

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

(14) CASE MANAGER INFORMATION:

NAME: _____

ADDRESS: _____

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

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

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

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 MOLINA MEDICAID SOLUTIONS.

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 NUMERIC ICD9-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 MOLINA:

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

PRIOR AUTHORIZATION UNIT NO IS 1- 225-928-5263

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