

CONTROL NUMBER * FOR ASC USE ONLY

Affiliated Computer Services, Inc.

AFFIX LABEL HERE

AFFIX LABEL HERE

STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DO NOT USE THIS FORM TO REQUEST LONG TERM CARE PLACEMENT

PRIOR AUTHORIZATION REQUEST

SEQUENCE NUMBER

P

(PLEASE TYPE)

FOR HEALTH CARE PROFESSIONAL (HCP) USE

FOR ACS USE

| | | |
|-------------------------|---------------------------|--|
| 1. HCP PHONE NO. () | 2. HCP IDENTIFICATION NO. | 3. REQUEST IS RETROACTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO |
|-------------------------|---------------------------|--|

20. HCP: YOUR REQUEST IS:
 APPROVED AS REQUESTED
 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)

4. HCP NAME AND ADDRESS
PLEASE
TYPE YOUR
NAME AND
ADDRESS
HERE

PRIOR AUTHORIZATION NUMBER
FROM DATE TO DATE
MM/DD/YY MM/DD/YY

AUTHORIZATION IS VALID FOR SERVICES PROVIDED
 DENIED

| | |
|-------------------------------------|---------------------|
| 5. RECIPIENT NAME (LAST, FIRST, MI) | 6. RECIPIENT ID NO. |
|-------------------------------------|---------------------|

BY _____
AUTHORIZING AGENT

| | | |
|-------------------|---------|------------------|
| 7. STREET ADDRESS | 8. SEX | 9. DATE OF BIRTH |
| | 10. AGE | |

| | |
|------------------|----------------------|
| 21. AGENT NUMBER | 22. DATE MM/DD/YY |
|------------------|----------------------|

| | |
|---------------------------|-------------------------|
| 11. CITY, STATE, ZIP CODE | 12. PHONE NUMBER () |
|---------------------------|-------------------------|

23. COMMENTS / EXPLANATION

| | |
|--|-------------------------------------|
| 13. DIAGNOSIS AND MEDICAL JUSTIFICATION: | 14. PRIMARY ICD-9-CM DIAGNOSIS CODE |
|--|-------------------------------------|

| 15. PROCEDURE/ DRUG CODE | M O D. | 16. SPECIFIC SERVICES REQUESTED | 17. REQUESTED UNIT / QTY | 18. CHARGES | AUTHORIZED | | 26. APPROVED UNIT / GTY | 27. APPROVED AMOUNT |
|--------------------------|--------|---------------------------------|--------------------------|-------------|------------|--------|-------------------------|---------------------|
| | | | | | 24. YES | 25. NO | | |
| 1 | | | | | | | | |
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19. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR HEALTH CARE PROFESSIONAL _____ TITLE _____ DATE _____

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

SEND WITH PART TWO
FORWARD THIS FORM TO: ACS, P.O. BOX 240808, ANCHORAGE, ALASKA 99524-0808
ORIGINAL COPY

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DO NOT USE THIS FORM TO REQUEST LONG TERM CARE PLACEMENT

PRIOR AUTHORIZATION REQUEST

SEQUENCE NUMBER

P

(PLEASE TYPE)

FOR HEALTH CARE PROFESSIONAL (HCP) USE

FOR ACS USE

| | | | | | | | | | | |
|---|--------|---------------------------------|--|--|------------------|--|-----------------------|----------------------------|-------------------------|---------------------|
| 1. HCP PHONE NO. () | | 2. HCP IDENTIFICATION NO. | | 3. REQUEST IS RETROACTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 20. HCP: YOUR REQUEST IS: <input type="checkbox"/> APPROVED AS REQUESTED <input type="checkbox"/> APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) | | | | |
| 4. HCP NAME AND ADDRESS PLEASE TYPE YOUR NAME AND ADDRESS HERE | | | | | | PRIOR AUTHORIZATION NUMBER FROM DATE TO DATE MM/DD/YY MM/DD/YY AUTHORIZATION IS VALID FOR SERVICES PROVIDED <input type="checkbox"/> DENIED BY _____ AUTHORIZING AGENT | | | | |
| 5. RECIPIENT NAME (LAST, FIRST, MI) | | | | 6. RECIPIENT ID NO. | | | | | | |
| 7. STREET ADDRESS | | | | 8. SEX | 9. DATE OF BIRTH | | 21. AGENT NUMBER | | | |
| | | | | 10. AGE | | | | | | |
| 11. CITY, STATE, ZIP CODE | | | | 12. PHONE NUMBER () | | | | 22. DATE MM/DD/YY | | |
| 13. DIAGNOSIS AND MEDICAL JUSTIFICATION: | | | | 14. PRIMARY ICD-9-CM DIAGNOSIS CODE | | | | 23. COMMENTS / EXPLANATION | | |
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| | | | | | | | | | | |
| 15. PROCEDURE/ DRUG CODE | M O D. | 16. SPECIFIC SERVICES REQUESTED | | 17. REQUESTED UNIT / QTY | 18. CHARGES | | 24. AUTHORIZED YES | 25. NO | 26. APPROVED UNIT / GTY | 27. APPROVED AMOUNT |
| 1 | | | | | | | | | | |
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| 6 | | | | | | | | | | |

19. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR HEALTH CARE PROFESSIONAL _____ TITLE _____ DATE _____

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SEND WITH PART TWO
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FISCAL AGENT COPY

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FOR ACS USE

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|-------------------------|---------------------------|--|
| 1. HCP PHONE NO. () | 2. HCP IDENTIFICATION NO. | 3. REQUEST IS RETROACTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO |
|-------------------------|---------------------------|--|

20. HCP: YOUR REQUEST IS:
 APPROVED AS REQUESTED
 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)

4. HCP NAME AND ADDRESS
PLEASE TYPE YOUR NAME AND ADDRESS HERE

PRIOR AUTHORIZATION NUMBER
FROM DATE TO DATE
MM/DD/YY MM/DD/YY

AUTHORIZATION IS VALID FOR SERVICES PROVIDED
 DENIED
 BY _____ AUTHORIZING AGENT

5. RECIPIENT NAME (LAST, FIRST, MI) 6. RECIPIENT ID NO.

7. STREET ADDRESS 8. SEX 9. DATE OF BIRTH
10. AGE

21. AGENT NUMBER 22. DATE
MM/DD/YY

11. CITY, STATE, ZIP CODE 12. PHONE NUMBER
()

23. COMMENTS / EXPLANATION

13. DIAGNOSIS AND MEDICAL JUSTIFICATION:
14. PRIMARY ICD-9-CM DIAGNOSIS CODE

| 15. PROCEDURE/ DRUG CODE | M O D. | 16. SPECIFIC SERVICES REQUESTED | 17. REQUESTED UNIT / QTY | 18. CHARGES | AUTHORIZED | | 26. APPROVED UNIT / GTY | 27. APPROVED AMOUNT |
|--------------------------|--------|---------------------------------|--------------------------|-------------|------------|--------|-------------------------|---------------------|
| | | | | | 24. YES | 25. NO | | |
| 1 | | | | | | | | |
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19. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR HEALTH CARE PROFESSIONAL TITLE DATE



A **xerox** Company

CERTIFICATE OF MEDICAL NECESSITY

| | |
|---|-----------------------------|
| Patient Name | Medicaid ID Number |
| Date Billed | Description of Item/Service |
| Procedure Code | |
| Reason for Item/Service/Equipment/Supplies | |
| Date Prescribed | Diagnosis |
| Prognosis | |
| Attending/Prescribing Physician Name/Medicaid Contract ID/NPI <div style="text-align: right;">_____</div> <div style="text-align: right;">Signature</div> | |
| Provider Name, Address, Medicaid Contract ID and NPI | |
| Provider Signature | Title |

Please attach this form to all claims requiring documentation of medical necessity.



**Affiliated Computer Services, Inc.
Certificate of Medical Necessity, Page 1 of 2**

Submitted by: _____

Date: _____

Recipient Name: _____

Ordering Provider's Name: _____

Medicaid #: _____

Medicaid ID# or AK License #: _____

Date of Birth: ___/___/___ Age: ___ Sex: ___ (M or F)

Telephone #: (___) ___-___ Ext. ___

HT: ___ (inches) WT: ___ (pounds)

Retrospective Review? ___ (Y/N)

Date of last visit: _____

SECTION A: CLINICAL INFORMATION

*(THIS SECTION **MUST** BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR AUDIOLOGIST.)*

DIAGNOSIS

ICD-9-CM

Estimated Length of Need (# of Months): _____ 1 – 99 (99 = Lifetime)

SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN: Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. *(THIS SECTION MAY BE COMPLETED BY THE ATTENDING SPECIALIST, INCLUDING THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH LANGUAGE PATHOLOGY THERAPIST, REGISTERED DIETITIAN, AUDIOLOGIST, OR OTHER ATTENDING SPECIALIST WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)*

PLAN: *The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.*

ATTESTATION, SIGNATURE AND DATE OF AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST (Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

A physician, nurse practitioner, physician assistant, audiologist or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Specialist – Title

Date

This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.

Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant

Date

I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.



**Affiliated Computer Services, Inc.
Certificate of Medical Necessity, Page 2 of 2**

Submitted by: _____

Date: _____

Recipient Name: _____

Ordering Provider's Name: _____

Medicaid #: _____

Medicaid ID# or AK License #: _____

Date of Birth: ___/___/___ Age: ___ Sex: ___ (M or F)

Telephone #: (____) _____ - _____ Ext. _____

SECTION C: REQUESTED SERVICES OR ITEMS
(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)

Provider Name: _____

Address: _____

Provider Medicaid No.: _____

Requester Name: _____

Telephone #: (____) _____ Ext. _____

Fax #: (____) _____ Ext. _____

Dates of Need – Start Date: _____ End Date: _____

ACS Use Only

Your request is:

Approved as requested

Approved as modified
(Items marked as authorized may be claimed.)

Prior Authorization Number: _____

From Date: _____ Thru Date: _____

Denied

Authorizing Agent Signature & Date:

Comments:

| | Procedure Code | Mod. | Description | QTY (#) | Charges | Authorized | | Approved Quantity | Approved Amount |
|----|----------------|------|-------------|---------|---------|------------|----|-------------------|-----------------|
| | | | | | | Yes | No | | |
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SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Signature of Supplier

Date



Affiliated Computer Services, Inc.
Certificate of Medical Necessity for Incontinence Supplies, Page 1 of 2

| | |
|---|---|
| Recipient Name: _____ Medicaid #: _____ Date of Birth: ___/___/___ Age: ___ Sex: ___ (M or F) | Ordering Provider's Name: _____ Medicaid ID # or AK License #: _____ Telephone #: (____) _____ - _____ Ext. _____ |
|---|---|

| | |
|--|-----------------------------------|
| HT: _____ (inches) WT: _____ (pounds) Date of last visit: _____ | Retrospective Review? _____ (Y/N) |
|--|-----------------------------------|

SECTION A: CLINICAL INFORMATION
 (THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT.)

| DIAGNOSIS | ICD-9-CM |
|-----------|----------|
| | |

Estimated Length of Need (# of Months): _____ 1-99 (99=Lifetime)

SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEMS(S) AND PLAN
 Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. (THIS SECTION MAY BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)

Plan: The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.

| | |
|---|--|
| <p><u>Daily</u> Usage Supplies (circle appropriate quantity):</p> <p>Disposable brief/undergarment 1 2 3 4 5 6 7 8 Other qty _____*</p> <p>Insert pads (used in briefs) 1 2 3 4 5 6 7 8 Other qty _____*</p> <p>Disposable bed pads 1 2 3 4 5 Other qty _____*</p> <p>** 1 unit = one tube or bottle up to 4 oz in size Ointment & Cream normally come in grams. Note: 1 oz = 30 gm or 30 ml</p> <p>***Note to supplier: If the packaging quantity is not the same as the 100/200/300/400/500 quantity circled, you may round to the nearest size packaging to avoid breaking open a package</p> | <p><u>Monthly</u> Usage Supplies (circle appropriate quantity):</p> <p>Reusable Bed Pads w/ or w/out flaps 1 2 3 4 Other qty _____*</p> <p>Gloves (per month): 100 200 300 400 Other qty _____*</p> <p>** Moisture Barrier Ointment/Gel 1 2 3 4 Other qty _____*</p> <p>** Moisture Barrier Cream 1 2 3 4 Other qty _____*</p> <p>** Moisture Barrier Lotion 1 2 3 4 Other qty _____*</p> <p>** Protectant Powder 1 2 3 4 Other qty _____*</p> <p>** Skin Cleanser 1 2 3 4 Other qty _____*</p> <p>*** Disposable wipes (each) 100 200 300 400 500 Other qty _____*</p> <p>*** Disposable wash cloths (each) 100 200 300 400 500 Other qty _____*</p> |
|---|--|

* If "other quantity" is completed, you must provide additional medical justification for the higher quantity requested.

Please note: These supplies are for incontinence treatment only and not for treatment of other areas of the body.

A physician, nurse practitioner, or physician assistant who attests to the medical necessity and quantity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws, and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

| | |
|--|---------------|
| _____ Signature of Provider – Title | _____ Date |
|--|---------------|

I hereby certify that I am the ordering physician, nurse practitioner or physician assistant identified in this form above.

Sections A and B must be completed by the attending physician, nurse practitioner or physician assistant.



Affiliated Computer Services, Inc.
Certificate of Medical Necessity for Incontinence Supplies, Page 2 of 2
 Submitted by: _____
 Date: _____

| | |
|---|--|
| Recipient Name: _____ Medicaid #: _____ Date of Birth: ___/___/___ Age: _____ Sex: _____ (M or F) | Ordering Provider's Name: _____ Medicaid ID# or AK License #: _____ Telephone #: (____) _____ - _____ Ext. _____ |
|---|--|

| | |
|---|--|
| SECTION C: REQUESTED SERVICES OR ITEMS <i>(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers.)</i> Provider Name: _____ Address: _____ Provider Medicaid #: _____ Requester Name: _____ Telephone #: (____) _____ Ext. _____ Fax #: (____) _____ Ext. _____ Dates of Need – Start Date: _____ End Date: _____ | <p align="center">ACS Use Only</p> Your request is: <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved as modified (Items marked as authorized may be claimed.) Prior authorization number: _____ From Date: _____ Thru Date: _____ <input type="checkbox"/> Denied Authorizing Agent Signature & Date: _____ Comments: _____ |
|---|--|

| | Procedure Code | Mod. | Description | QTY (#) | Charges | Authorized | | Approved Quantity | Approved Amount |
|----|----------------|------|-------------|---------|---------|------------|----|-------------------|-----------------|
| | | | | | | Yes | No | | |
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SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

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 Signature of Supplier

 Date