

Standardized Prior Authorization Request Form Instructions

Last modified: 9/2024

The one-page Standardized Prior Authorization Request Form is to be used by all NH Medicaid fee-for-service (FFS) and managed care organization (MCO) service providers to obtain service authorization for their Medicaid-enrolled beneficiaries for specific services that require service authorization. This does not substitute NH Medicaid FFS or NH Medicaid MCO service authorization policies, and a copy of all supporting information is still required. The following instructions provide information on how to complete all items on the form and include a list of acronyms at the end of the document. The instructions provide details about each item and explain the nuances of how to answer the items. A copy of the standard prior authorization form with numbers corresponding to the items in these instructions can be found on the last page of this document.

Services covered:

The form should be used for all MCO and NH Medicaid FFS services requiring authorization, with the exception of:

1. **Behavioral health services.**
2. **Radiology.**
3. **Nonemergent medical transportation (NEMT).**
4. **Pharmacy in most instances; see item 3 below for clarification.**
5. **Durable medical equipment (DME) for Well Sense and New Hampshire Medicaid FFS. AmeriHealth Caritas New Hampshire and New Hampshire Healthy Families (NHHF) use the form for DME at this time.**

Information is entered on the Standardized Prior Authorization Request Form in several ways:

1. **Writing in specific data, including dates, numbers, narrative (e.g., items 1, 1b, 13, and 14).**
2. **Checking boxes (e.g., items 1a, 2, 3, and 4):**
 - a. Select one.
 - b. Select all that apply.
3. **Writing in comments (e.g., item 29).**

Introduction:

1. **Health plan:** Enter name of authorizing entity (e.g., AmeriHealth Caritas New Hampshire, NHHF, Well Sense, New Hampshire Medicaid FFS).

a. Please choose one:

For urgent requests: Determinations made within 72 hours of the receipt of request, where application of the time frame for making standard determinations could:

- Seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state.
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For standard requests: Determinations that are not urgent.

Note: Emergency services to screen and stabilize the member do not require approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

- b. **Health plan fax number:** Enter authorizing entity fax number including area code (e.g., 1-603-555-1234)

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Service type requiring authorization (check all that apply):

2. **Ambulatory/outpatient services:**

- a. **Surgery/procedures:** This should be selected if the request is for a surgery or procedure. If the surgery or procedure will be inpatient, please also check the inpatient box and indicate the planned admission date in box #25.
- b. **Chiropractic:** This should be selected if the request is for chiropractic services

3. **Pharmacy:** Select this for medication requiring authorization when covered as part of the medical benefit. Other medication authorizations are processed/authorized through pharmacy benefit management (PBM). For FFS, indicate where the infusion is taking place.

4. **Inpatient care/observation:** These are all general inpatient service classifications based on location/duration or severity of service needed. An admission date is required in box #25. Notification is required in advance of the admission or within 24 hours of admission if the admission was an emergency. As of February 2016, skilled nursing facilities are currently not covered by the MCOs. For New Hampshire Medicaid FFS, please provide revenue codes in the additional comments section under authorization request (box #29) for inpatient care in an out-of-state hospital.

5. **Outpatient therapy:** Select the appropriate therapy type when the request is for these services to be performed in an outpatient setting. Please indicate the proposed start and end dates and the number of visits/days or units in the authorization section. For New Hampshire Medicaid FFS, please provide the revenue code and CPT codes under the additional comments section (box #29).

6. **Nutrition:** Select one of these when requesting the medical benefit to cover these services.

7. **Home health/hospice:** For services performed **in the home**, please select all specific services

that apply. If selecting more than one service, please specify in the additional comments section under authorization request (box #29) the requested number of visits or units and date range for each service requested. If selecting home health, please check off all services that apply. If the member lives in a nursing home or other residential facility, this is considered their home, and these would be considered in-home services. If services are not provided in the home, please use outpatient therapy (box #5).

For Personal care attendant services, please include the Self Care and Function Evaluation (SCFE) Form.

8. **Dental:** Select this service type for MCO-covered anesthesia if required for dental procedures. Select miscellaneous for New Hampshire Medicaid-covered dental services. Further specifications should be provided in box 10, "Other — please specify service." Please include dollar amount for New Hampshire Medicaid FFS.

9. **Out-of-network request — please specify service:** Any out-of-network service request should have a notation here. If there is not a service type category listed, please note the specific service. For example, office visits or consults to out-of-network providers require authorizations.

10. **Other — please specify service:** Anything that does not meet the guidelines of the listed service types should be indicated here. For example, a second appointment on the same day at a federally qualified health center (FQHC).

For NHHF, request DME in this section.

Member information:

11. **Member ID:** For managed care, enter member's unique MCO identification number. For New Hampshire Medicaid FFS, enter member's unique Medicaid identification number.

12. **Date of birth:** Enter member's date of birth in month/day/year format (e.g., 01/01/2012).

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13. **Last name, first name:** For managed care, enter member's name as it appears on the MCO card. For New Hampshire Medicaid FFS, enter member's name as it appears on the Medicaid card.

Requesting provider information:

14. **Requesting NPI:** Enter the requesting provider's NPI number. For New Hampshire Medicaid FFS, please provide the New Hampshire Medicaid provider number.

15. **Requesting TIN:** Enter the requesting provider's TIN.

16. **Requesting provider:** Enter name of the provider who is requesting the service authorization.

17. **Contact at requesting provider's office:** Enter name of the provider office contact that can answer questions and clarify information on the Standardized Prior Authorization Request Form.

a. **Phone:** Enter contact's business phone number including area code (e.g., 1-603-555-1234).

b. **Fax:** Enter contact's business fax number including area code (e.g., 1-603-555-5678).

Servicing provider/ facility information:

Note: Complete this section even if the requesting provider is the servicing provider.

18. **Please choose one:** For managed care, select whether the provider is participating or not in the health plan's provider network. For New Hampshire Medicaid FFS, select whether the provider is participating or not in New Hampshire Medicaid.

19. **Servicing NPI:** Use the NPI of the billing provider. For NH Medicaid FFS, please provide the NH Medicaid provider number.

20. **Servicing TIN:** Use the TIN of the billing provider.

21. **Servicing provider:** Enter name of provider that will be performing the requested service.

a. **Servicing facility name:** Enter name of facility that will be performing the requested service.

22. **Servicing provider contact name:** Enter name of service provider office contact that can answer questions or clarify information.

a. **Phone:** Enter contact's business phone number including area code (e.g., 1-603-555-1234)

b. **Fax:** Enter contact's business fax number including area code (e.g., 1-603-555-5678)

Authorization request:

23. **Primary procedure code(s):** Indicate the exact procedure code you are looking to have authorized

Modifiers, if applicable: Include any applicable modifiers.

24. **Additional procedure code(s):** Add any additional codes that you are seeking authorization for. If you are unsure if you will be performing the additional codes, consider adding them for authorization to avoid claims issues after the fact.

Modifiers, if applicable: Include any applicable modifiers.

For private duty nursing (PDN) only: For PDN, indicate if the request is for daytime/evening, night/weekend, or a ventilator. This will ensure the appropriate modifiers are included in the authorization.

25. **Start date or admission date:** The planned start date or admission date. If this is an emergency admission, please include the actual admission date.

26. **Diagnosis code:** Indicate the diagnosis code (version ICD-10).

27. **End date or discharge date:** If the service has a planned end date, please indicate it. If the discharge has occurred, please indicate what the discharge date was.

28. **Total units/visits/days:** Some services, like visiting nurse or pain management, have planned days or visits. Please indicate what is being requested (days or visits) and how many.

29. **Additional comments:** Any comments to help process the request.

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Contacts:

For questions resulting from completing the form for New Hampshire Medicaid FFS or the MCOs, please contact:

New Hampshire Medicaid FFS

1-603-271-9384 (phone)

1-603-271-8194 (fax)

AmeriHealth Caritas New Hampshire

1-833-472-2264 (phone)

1-833-469-2264 (fax)

<https://www.amerihhealthcaritasnh.com/provider/resources/navinet.aspx> (provider portal)

NHHF

1-866-769-3085 (phone)

1-866-270-8027 (main fax)

1-833-782-0053 (buy & bill pharmacy fax)

1-877-658-0322 (STRS fax)

Well Sense

1-877-957-1300 (phone)

1-603-218-6634 (fax)

Acronym List:

| | |
|-------------|------------------------------------------|
| ABA | Applied behavior analysis |
| DME | Durable medical equipment |
| FFS | Fee for service |
| FQHC | Federally qualified health center |
| HHA | Home health aid |
| ID | Identification |
| MCO | Managed care organization |
| MSW | Master Social Worker |
| NCQA | National Committee for Quality Assurance |
| NEMT | Nonemergent medical transportation |
| NPI | National Provider Identifier |
| OT | Occupational therapist |
| PDN | Private duty nursing |
| PBM | Pharmacy benefit management |
| PT | Physical therapist |
| SCFE | Self care and function evaluation |
| SN | Skilled nursing |
| ST | Speech therapist |
| TIN | Tax Identification Number |

Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THIS FORM.
A COPY OF ALL SUPPORTING INFORMATION IS REQUIRED. LACK OF INFORMATION MAY RESULT IN DELAY OR DISMISSAL OF REQUEST.

Prior authorization request form and required clinical information should be sent to:



or



or



or



NH Medicaid Fee-For-Service

| Health plan: | <input type="checkbox"/> Urgent <input type="checkbox"/> Standard | Health plan fax: |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Service type requiring authorization (check all that apply) | | |
| Ambulatory/ outpatient services <input type="checkbox"/> Surgery/ procedure <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pain management <input type="checkbox"/> DME <input type="checkbox"/> Laboratory testing <input type="checkbox"/> Pharmacy | Outpatient therapy (out of home only) <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Pulmonary/ cardiac rehab <input type="checkbox"/> ABA therapy | Home health/ hospice <input type="checkbox"/> Home health (Please check: <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> HHA <input type="checkbox"/> MSW <input type="checkbox"/> Private duty nursing) <input type="checkbox"/> Personal care attendant (Please include SCFE form.) <input type="checkbox"/> Hospice <input type="checkbox"/> Infusion therapy |
| Inpatient care/ observation <input type="checkbox"/> Acute medical/ surgical <input type="checkbox"/> Obstetrical <input type="checkbox"/> Long-term acute care <input type="checkbox"/> Acute rehab <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Observation <input type="checkbox"/> NICU <input type="checkbox"/> Transplant | Nutrition <input type="checkbox"/> Nutritional counseling <input type="checkbox"/> Enteral nutrition <input type="checkbox"/> Infant formula <input type="checkbox"/> Total parenteral nutrition | Dental <input type="checkbox"/> Anesthesia <input type="checkbox"/> Misc (specify in other below) |
| <input type="checkbox"/> Out-of-network request — please specify service: | | |
| <input type="checkbox"/> Other — please specify service: | | |

| Member information (*denotes required field) | |
|----------------------------------------------|-----------------|
| *Member ID: | *Date of birth: |
| *Last name, first name: | |

| Requesting provider information (*denotes required field) | | |
|-----------------------------------------------------------|------------------|-----------------------|
| *Requesting NPI: | *Requesting TIN: | *Requesting provider: |
| Contact at requesting provider's office: | *Phone: | *Fax: |

| Servicing provider/ facility information (*denotes required field) | | |
|-------------------------------------------------------------------------------------------------------|---------------------------|-----------------|
| *Please choose one: <input type="checkbox"/> Participating <input type="checkbox"/> Non-participating | *Servicing NPI: | *Servicing TIN: |
| *Servicing Provider: | *Servicing Facility Name: | |
| *Contact at Servicing Provider's Office: | *Phone: | *Fax: |

| Authorization request (*denotes required field) | |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| *Primary procedure code(s): | *Start date or admission date: |
| Modifiers, if applicable: | *Diagnosis code: |
| *Additional procedure code(s): | *End date or discharge date: |
| Modifiers, if applicable: | Total units/ visits/ days: |
| For PDN only: <input type="checkbox"/> Daytime/evening <input type="checkbox"/> Night/ weekend <input type="checkbox"/> Vent | |
| Additional comments: | |

| Please refer to the following payer websites for additional information regarding plan-specific requirements for services that require prior authorization. | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------|
| ACNH www.amerihealthcaritasnh.com | NHHF www.nhhealthyfamilies.com | WSHP www.wellsense.org | NH Medicaid FFS www.nhmmis.nh.gov |

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

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