

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) <input type="checkbox"/> 01-Outpatient Surgery Performed Inpatient Hospital <input type="checkbox"/> 05 Rehabilitation Therapy <input type="checkbox"/> 09 DME equipment & Supplies <input type="checkbox"/> 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 (8) (MMDDYYYY)

DIAGNOSIS: (8) PRIMARY CODE & DESCRIPTION _____ SECONDARY CODE & DESCRIPTION _____	PRESCRIPTION DATE (9) (MMDDYYYY) 	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE 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)				DESCRIPTION (11B)	REQUESTED (11C)		AUTHORIZED (11D)		STATUS	P.A. MESSAGE / DENIAL CODE (S)
	Mod 1	Mod 2	Mod 3	Mod 4		UNITS	AMOUNT	UNITS	AMOUNT		

(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: (____) _____
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(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.

- 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 HCPCS/ PROCEDURE CODE'S 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 IT IS 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

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P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
REHABILITATION SERVICES REQUEST

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

LIMITATIONS : ___ AMBULATORY ___ NON - AMBULATORY ___ YES ___ NO TRANSPORTATION AVAILABLE
AIDS NEEDED: ___ WALKER ___ CANE ___ WHEELCHAIR ___ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION

IF INITIAL , INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED

IF EXTENSION, PRIOR ATTENDANCE : _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES: PROCEDURE CODE DESCRIPTION FREQUENCY TIME / VISIT TOTAL UNITS

PHYSICAL THERAPY: _____

SPEECH THERAPY: _____

OCCUPATIONAL
THERAPY _____

LENGTH OF PLAN SERVICE: FROM: _____ TO : _____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE - EVALUATION: _____
MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

REQUESTED BY : _____ DATE: _____