Division of Medical Services

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER					
☐ **INITIAL** ☐ **RECERT** ☐ **MODIFICATION** ☐ **EXT OF BENEFITS**			**START DATE:**		
PROVIDER NAME:			**PROVIDER MAILING ADDRESS:**		
PROVIDER IDENTIFICATION #/TAXONOMY CODE:			**PROVIDER PHONE & CONTACT PERSON:**		
BENEFICIARY NAME: (LAST, FIRST, MI)			**BENEFICIARY MEDICAID ID #:**		
BENEFICIARY MAILING ADDRESS:			**DATE of BIRTH:**	**SEX:** ☐ **MALE** ☐ **FEMALE**	
PRESCRIBING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE (APRN):			**PROVIDER IDENTIFICATION #/TAXONOMY CODE:**		
PROCEDURE CODE	**MOD 1**	**MOD 2**	**TOS**	**DESCRIPTION OF ITEMS REQUESTED**	**UNITS REQUESTED**

I attest that the above information is true to the best of my knowledge.

_____ _____

PROVIDER SIGNATURE **DATE**

SECTION B - TO BE COMPLETED BY THE PHYSICIAN/APRN			
EST. LENGTH OF NEED: _____**WKS** _____ **MONTHS** _____**PERM**	**EPSDT REFERRAL:** ☐ **YES** ☐ **NO** ☐ **N/A**	**CURRENT HEIGHT:** **INCHES**	**CURRENT WEIGHT:** **LBS**
DIAGNOSIS & ICD CODE:	**DIAGNOSIS & ICD CODE:**	**DIAGNOSIS & ICD CODE:**	

IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? ☐ **YES** ☐ **NO**

MEDICAL NECESSITY FOR REQUESTED SERVICES:

_____ _____

PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE SIGNATURE **DATE**

****A prescription for the requested items <u>MUST</u> be documented above or a separate prescription <u>MUST</u> be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from either the prescribing physician or advanced practice registered nurse WILL be required.**

Please retain a copy of this form in your files.

Send completed form to:

Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters

PO Box 180001

Fort Smith, AR 72918-0001

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

REVIEW TYPE:	Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
DATE(S) OF SERVICE REQUESTED:	Enter the requested date(s) of service.
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PHYSICIAN/APRN INFORMATION:	Enter the prescribing physician/advanced practice registered nurse's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN/APRN

EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician/APRN expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician/APRN expects that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is being made as the result of an EPSDT referral.
HEIGHT & WEIGHT:	Enter the beneficiary's current height measured in inches and weight measured in pounds.
DIAGNOSIS & ICD CODES:	In the first space, list the diagnosis & ICD code that represents the primary reason for ordering this item. List any additional diagnosis & ICD codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
MEDICAL NECESSITY:	The physician/APRN within scope of practice must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are not acceptable.
**PRESCRIPTION:	A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
**LETTER OF MEDICAL NECESSITY:	If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician/APRN WILL be required.