Request prior authorization for Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Personal Care Service

Fax to: **1-225-216-6481**	Continuation of services ☐ Yes ☐ No	P.A. No.
NPI:	TIN:	

1. Prior authorization type: **14 – EPSDT personal care services**	**2.** Beneficiary Medicaid ID No. or CCN No.	**3.** Social Security No.
4. Beneficiary name _____ Last name First name MI		**5.** Date of birth
6. Medicaid Provider No.	**7.** Service treatment plan Begin date End date	**8.** Is beneficiary currently receiving these services? ☐ Yes ☐ No
9. Diagnosis: Primary code Secondary code		**10.** Prescription date
11. Prescribing practitioner's name and/or No.		
Practitioner Reviewer's signature	Date	Status codes: 2 = Approved; 3 = Denied

Description of services				For internal use only			
Procedure code	Modifer	Personal care service each 15 minutes	Requested units	Authorized units	Status	P.A. message/ denial code(s)	

13. Provider name _____ Address _____ City _____ State _____ ZIP code _____ Telephone No. _____ Fax No. _____	Comments:
14. Provider signature	**15.** Date of request:

Humana Healthy Horizons® in Louisiana

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Instructions for completing prior authorization form (PA-14)

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 DXC.

2. Enter beneficiary's 13-digit Medicaid ID number or the 16-digit CCN number.

3. Enter the beneficiary's Social Security Number.

4. Enter the beneficiary's last name, first name and middle initial as it appears on the beneficiary's Medicaid ID card.

5. Enter the beneficiary's date of birth in mm/dd/yyyy format (mm=month, dd=day, yyyy=year).

6. Enter the provider's 7-digit Medicaid number.

7. Enter the first day the service is requested to start and the last day of service for that individual treatment plan in mm/dd/yyyy format (mm=month, dd=day, yyyy=year.

8. Place a check mark in the 'yes' or 'no' box to indicate whether or not the beneficiary is currently receiving services.

9. Enter the diagnosis codes (primary & secondary).

10. Enter the day the prescription, practitioner's orders was written in mm/dd/yyyy format (mm=month, dd=day, yyyy=year)

11. Enter the name of the beneficiary's attending practitioner prescribing the services.

12. Enter the HCPS code.

12a. Enter the corresponding modifier (when appropriate).

12b. Enter the HCPS code's corresponding description for each procedure requested.

12c. Enter the number of times the requested procedure will be performed during the treatment plan. Calculate the total units requested by multiplying the number of units per day (1 unit = 15 minutes) times the number of days per week times the number of weeks covered in the treatment plan. This will give the total units requested. Below are two examples on the proper way to calculate the total units requested:

Example 1. Requesting 4 hours per day for a 6-month period:
4 hours per day = 16 units per day, 7 days a week, 26 weeks = 16 x 7 x 26 = 2,912 total units requested

Example 2. Requesting 2 hours per day on weekends and 4 hours per day on weekdays:
2 hours per day (weekends) = 8 units per day, 2 days a week, 26 weeks = 8 x 2 x 26 = 416 total units requested for weekends

4 hours Per day (weekdays) = 16 units per day, 5 days a week, 26 weeks = 16 x 5 x 26 = 2,080 total units requested for weekdays

The total units requested would be the combination of the total weekend units (416) and weekday units (2,080), which would equal to 2,496 total units requested. This is the number (2,496) to enter in field number 12c.

13. Enter the name, mailing address and telephone number of the provider of service.

14. 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.

15. 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 DXC.

Prior authorization PCS department toll-free number is **1-800-807-1320**
Prior authorization fax number is **1-225-216-6481**