DME Medical Supplies & Equipment Prior Authorization Request Form
Qualis Health-WYDOH

Qualis Health - WYDOH requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) with their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.comlziP4/welcome.jsp

Submit fax request for Prior Authorization to: (877) 810-9265
Requests may be submitted up to 30 days prior to schedule procedures/services, provided Client is eligible.

1. ☐ Initial	☐ Recertification	☐ Change	☐ Cancel	Recert: Enter previous PA#. Change or Cancel: Enter PA# to be changed or canceled.	PA#
2. Date of Request (mm/dd/yyyy) / /	3. Review Type (check one if applicable) ☐ Prior Authorization ☐ Retrospective Prepayment Review (Date notified of eligibility mm/dd/yyyy)				
4. Client Medicaid ID Number (10 digit Number):	5. Client Last Name:	6. Client First Name:	7. Date of Birth (mm/dd/yyyy): / /	8. Gender: Male ☐ Female ☐	
9. a. NPI/Requesting Service Provider Name & ID Number: b. 9 digit Zip Code (Mandatory)	10. Treatment Setting ☐ Outpatient	11. Primary Diagnosis Code/ Description: (enter up to 5) 1. 2. 3. 4. 5.			
12. a. NPI/Rendering Provider Name and ID Number: b. 9 digit Zip Code (Mandatory)	13. Prior Auth Service Type: ☐ DME				
14. Clinical Information (See service type specific instructions):					

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Number	15. HCPCS/ CPT Code	16. Code Description	17. Modifiers (if applicable)	18. Units Requested (If Applicable)	19. Frequency	20. Dates of Service	
						From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.						/ /	/ /
2.						/ /	/ /
3.						/ /	/ /
4.						/ /	/ /
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12.						/ /	/ /
13.						/ /	/ /
14.						/ /	/ /
15.						/ /	/ /
16.						/ /	/ /
17.						/ /	/ /
18.						/ /	/ /
21. Contact Name:							
22. Contact Telephone Number:							
23. Contact Fax Number:							

Additional Information

14. Clinical Information

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INSTRUCTIONS FOR OUTPATIENT REVIEW SUBMISSION FORM

All DME Forms can be found in the DME Forms section here: http://wymedicaid.acs-inc.com/forms.html

This review submission form may be used for **WY DME Medical Supplies & Equipment** PA requests for Initial Certification, Recertification, and Retrospective Review and submitted either through the Qualis Health Provider Portal (QHPP) or to the Qualis Health fax number.

Please be certain that all information blocks contain the requested information.

If Qualis Health determines that your request meets appropriate coverage criteria guidelines. Final approval is contingent upon passing remaining Client and Provider eligibility/enrollment edits. The Prior Authorization (PA AUTH) number will be provided to you via the QHPP or by telephone.

1. **Request type:** Place a ✓ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. . Resubmitting a request after 30 days from the date of a denial would be an initial request also
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous Prior Authorization would be a recertification request.
   - **Change:** A change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **NOTE:** All changes to the original request for **Medical Supplies & Equipment must be accompanied by a new CMN**
   - **Cancel:** Use to cancel all or some of the items under one Prior Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Client number.
2. **Date of Request**: The date you are submitting the Prior Authorization request.
3. **Review Type**: Place a ✓ or **X** in the appropriate box. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Client Medicaid ID Number**: It is the provider's responsibility to ensure the Client's Medicaid number is valid. This should contain 10 digits
5. **Client Last Name**: Enter the Client's last name exactly as it appears on the Medicaid card.
6. **Client First Name**: Enter the Client's first name exactly as it appears on the Medicaid card.
7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Gender**: Please place ✓ or **X** to indicate the sex of the client.
9. **a. NPI Requesting /Service Provider Name and ID Number**: Enter the requesting/service provider name and National Provider Identifier (NPI).

b. **9 digit Zip Code (Mandatory)**: Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.

I0. **Treatment Setting:** Place a ✓ or **X** to indicate the place of service

11. **Primary Diagnosis Code/ Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).

12. **a. NPI Rendering Provider Name and ID Number:** Enter the rendering provider name and National Provider Identifier (NPI) for the provider performing the service.

b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted,

13. **Prior AUTH Service Type:** Place a. ✓ or **X** to indicate the category of service you are requesting

14. **Clinical Information:**

- Knowledge of McKesson InterQual/WYDOH Medical Supplies & Equipment guidelines criteria will be helpful to provide pertinent information.
- Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions / % as appropriate]).
- This field must include the treatment plan for the client. List the services, procedures, or treatments that will be provided to the client.

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- Service Type specific instructions:

DME	Attach Certificate of Medical Necessity to PA request – to download a CMN go to: http://wymedicaid.acs-inc.com/forms.html. All forms can be found in the DME Forms section. • Optional forms for Wheelchair necessity and Electric Breast Pump CMN and Parenteral Nutrition Necessity are located at the above website and can be used in addition to the CMN and fax form. • **Completed** Certificate of Medical Necessity must be signed and dated by Physician, Physician Assistant or Nurse Practitioner (date must be prior to start of Services). • Initial date of need or start date must be included on CMN • Estimated total length of time equipment will be needed must be noted • A new CMN is required every twelve months or when there is a change in the prescription supplies. • A new CMN is required for any changes in the previous order, new start date and signature by Physician, Physician Assistant or Nurse Practitioner prior to onset of change.

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15. **HCPCS/CPT:** Provide the HCPCS/CPT procedure code.
16. **Code Description:** Provide the HCPCS/CPT procedure code description.
17. **Modifiers (if applicable):** Enter modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Accessories.
18. **Units Requested:** Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of lnterQual WYDOH criteria will be extremely helpful. Place numbers only in the Units Requested block. (if Applicable)
19. **Frequency:** Enter Frequency usage of Service requested- (if Applicable)
20. **Dates of Service:** Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
21. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.
22. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
23. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.