DMAS Specialized Treatment Bed Pre-Authorization Form fax to (804)371-4986

Facility Name _____ Provider # _____ Date of Request _____

Facility Contact Person _____ Contact phone # _____
Fax # _____

Type of Request ___ Initial (82 days)
___ Previously approved/New Ulcer
___ Post surgical flap (41 days)

Recipient Name _____ Medicaid Number _ _ _/_ _ _/ _ _ _/ _ _/ _

Location	Date of Stage IV Onset*	Width	Depth	Length	Description of Ulcer

Date of original physician order for Specialty Bed ___/___/___ Type of Specialty Bed___Low Air Loss bed ___ Air Fluidized bed
Physician order on file at NF (check type)

**RAI MDS Classification – Stage IV: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.*

DMAS USE only DMAS Received Date: _____

____ Approved for_____Days Preauthorization Number: _____ Effective Date: _____
____ Denied/Reason: Requested Service does not meet DMAS policy criteria for reimbursement

You may request reconsideration of this denial within 30 days of receipt. You may fax your request to the above number or you may write to

Department of Medical Assistance Services
Attention: Supervisor Facility and Home Based Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Preauthorization does not guarantee reimbursement. *PLEASE PRINT OR TYPE.*

DMAS-258 (10/04)

Instructions for Completing DMAS Specialty Bed Pre-Authorization Form

Demographic Information

Facility Name – Enter your facility name
Provider Number – Enter the Medicaid provider number for your facility
Date of Request – Enter the date that you are submitting the request to DMAS
Facility Contact Person – Enter the name of the facility contact that DMAS may call if there are questions.
Contact Number – Enter the telephone number for the facility contact person.

- **Type of Request** – Check Initial if this is the original/new on-set request for this resident;
- Check Previously approved/ New Ulcer if the resident has been authorized a bed previously. A resident may qualify for up to 246 days in a calendar year for a bed. The patient must have a new Stage IV Ulcer and have 30 days between the requests.
- Check post surgical flap if the recipient has received a surgical flap for their Stage IV pressure ulcer and needs to be placed on a therapeutic bed. This is for new post surgical requests not for recipients who were on a bed and then received a flap.

Recipient Name – Enter the complete [first/middle/last] name of the resident.
Medicaid Number – Enter the Medicaid number [12 digits] for the resident.

Pressure Ulcer Information

List and provide information for each Stage IV ulcer [if additional space is needed use a separate form and label form as page 1 of 2 [or 2 of 2 pages, etc.] for resident [insert name]
Location – Enter the location of the pressure ulcer [i.e. sacrum, left hip, right outer ankle, etc.]
Date of Onset – Enter the date [month/day/year] of on-set for the pressure ulcer.
Stage – Enter the current stage of the ulcer; use MDS terminology and guidelines for staging.
Dimensions – Enter the width, length, and depth of the ulcer using centimeter measurements.
Description of Ulcer – Provide information on ulcer such as any drainage, odor, etc.

Other information needed

Date of Physician Order – Enter the original date of the physician order for the specialty bed.
Type of Bed – Check the type of bed being ordered by the physician [Low Air Loss or Air Fluidized]; note physician order should be specific for type of bed and should not use generic terms such as specialty bed; pressure reduction bed, etc; physician order does not have to include brand name of the bed.
Physician Order/Certification – Have the physician sign the request certifying that the bed is necessary for treatment of the pressure ulcer and have them date [month/day/year] their signature.

Submit the request to

DMAS – Facility and Home Based Services Unit
FAX # 1-804-371-4986