VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST

1 Original ☐ 2 Cancel ☐ 3 Change ☐

SERVICING PROVIDER INFORMATION

Number: 4

Name: 5

Contact Person: 6

Phone: 7

Enrollee ID# : 8

Enrollee Name:

Last: 9

First: 10

MI: 11

Referring Provider # 12

13 ☐ Other Non-Paper Enclosure

14 ☐ X-Rays Enclosed

15 ☐ Photographs Enclosed

Diagnosis Code: 16

PA Number: 17 (If cancellation or change)

PA Service Type: 18

1
19 ☐ HCPCS/CPT
20 ☐ Revenue Code 21
Modifiers (If Applicable) 22
Units Requested: 23
Amount Requested: 24
Desc: 25
Line # (If Requesting Cancellation Or Change) 26
Dates of Service Requested (MM/DD/YY) From: 27 To: 28

2
19 ☐ HCPCS/CPT
20 ☐ Revenue Code 21
Modifiers (If Applicable) 22
Units Requested: 23
Amount Requested: 24
Desc: 25
Line # (If Requesting Cancellation Or Change) 26
Dates of Service Requested (MM/DD/YY) From: 27 To: 28

3
19 ☐ HCPCS/CPT
20 ☐ Revenue Code 21
Modifiers (If Applicable) 22
Units Requested: 23
Amount Requested: 24
Desc: 25
Line # (If Requesting Cancellation Or Change) 26
Dates of Service Requested (MM/DD/YY) From: 27 To: 28

4
19 ☐ HCPCS/CPT
20 ☐ Revenue Code 21
Modifiers (If Applicable) 22
Units Requested: 23
Amount Requested: 24
Desc: 25
Line # (If Requesting Cancellation Or Change) 26
Dates of Service Requested (MM/DD/YY) From: 27 To: 28

5
19 ☐ HCPCS/CPT
20 ☐ Revenue Code 21
Modifiers (If Applicable) 22
Units Requested: 23
Amount Requested: 24
Desc: 25
Line # (If Requesting Cancellation Or Change) 26
Dates of Service Requested (MM/DD/YY) From: 27 To: 28

6
19 ☐ HCPCS/CPT
20 ☐ Revenue Code 21
Modifiers (If Applicable) 22
Units Requested: 23
Amount Requested: 24
Desc: 25
Line # (If Requesting Cancellation Or Change) 26
Dates of Service Requested (MM/DD/YY) From: 27 To: 28

FOR ADDITIONAL PROCEDURES FOR THE SAME PA #, USE AN ADDITIONAL FORM -
ENTER BOXES 4, 5, 12, 13, 14, AND 15 ON EACH ADDITIONAL FORM

29 Provider Signature: ______________________ 30 Date Signed: ____________

Instructions For Completion of the DMAS 351 – Virginia Department of Medical Assistance Services "Prior Review and Authorization Request" Form

The DMAS 351 is to be used when requesting a new prior authorization, to request a change an existing authorization, or to cancel an existing authorization. Note: A cancellation request can only be honored if there has been no claims activity posted against the authorization.

HEADER DATA

1 – 3	Put an "X" in the box next to the type of request being submitted.
4 – 7	Servicing Provider Information: includes provider ID #, name, , a contact person's name, and telephone number.
8 – 11	Enrollee (Patient) Information: includes enrollee ID#, last name, first name, middle initial.
12	Referring Provider ID # (if applicable).
13 – 15	Indicate if attaching a non-paper enclosure, x-ray, or photograph for review.
16	Enter the primary diagnosis code for the enrollee.
17	Enter the PA Number (tracking number) if requesting a change or cancellation.
18	Enter the appropriate PA Service Type. (See listing in Provider Manual with these instructions.

LINE ITEM DATA

Each form will accommodate up to 6 lines of requests for authorization of services or equipment. If more than 6 lines are needed, use additional DMAS-351's to request additional services or equipment. Be sure to indicate the number of the pages being submitted (top right), especially if more than one DMAS-351 is required.

19 – 25	Indicate the type of procedure code, the procedure code, up to 4 modifiers (if applicable), the number of units requested, amount requested, and a description of the item/service requested.
26	Enter the line # for which you are requesting a change or cancellation.
27 – 28	Enter the From Date and To Date of Service
29 – 30	Provider's signature and date signed.

ATTACHMENTS

Attach required and supportive medical documentation to the completed DMAS-351 and submit to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261