VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST
SUPPORTING DOCUMENTATION

1 ☐ Return Pend Documentation

2 ☐ Request for Reconsideration
(Check only (1) box)

Pending or Denied PA # (if known)

3 _____

4 Check appropriate box(es)

Line 1 ☐	Line 2 ☐	Line 3 ☐	Line 4 ☐	Line 5 ☐	Line 6 ☐
Line 7 ☐	Line 8 ☐	Line 9 ☐	Line 10 ☐	Line 11 ☐	Line 12 ☐
Line 13 ☐	Line 14 ☐	Line 15 ☐	Line 16 ☐	Line 17 ☐	Line 18 ☐

PROVIDER INFORMATION

Number: 5 _____

Name: 6 _____

Contact Person: 7 _____

Phone: 8 _____

Enrollee ID# : 9 _____

Enrollee Name:

Last: 10 _____

First: 11 _____

MI: 12 ☐

13 ☐ Other Non-Paper Enclosure

14 ☐ X-Rays Enclosed

15 ☐ Photographs Enclosed

16 ☐ Dental Models Enclosed

PA Service Type: 17 _____

18 COMMENTS: _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE, ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

19 Provider Signature _____ 20 Date Signed _____

Instructions For Completion of the DMAS-361
Virginia Department of Medical Assistance Services
"Prior Review and Authorization Request Supporting Documentation"

The DMAS-361 is to be used when returning requested documentation in response to a pend, to request reconsideration of an adverse prior authorization decision, or if sending in orthodontic models separate from the prior authorization request. This form and applicable attachments should be submitted to:

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

INSTRUCTIONS BY INDICATOR NUMBER:

1. Return Pend Documentation:	Mark with an "X" if returning documentation in response to a pend.
2. Request for Reconsideration:	Mark with an "X" if requesting reconsideration in response to an adverse prior authorization decision.
3. Pending or Denied PA#:	Enter the PA or Tracking Number (if known). If sending in orthodontic models for authorization, leave this field blank.
4. Check appropriate box(es):	Identify which line(s) of the Prior Authorization to refer to.
5. Provider Number:	Enter the provider's Medicaid ID #.
6. Name:	Enter the provider's name.
7. Contact Person:	Enter a Contact's name representing the provider.
8. Phone:	Enter the telephone number at which the Contact can be called.
9. Enrollee ID #:	Enter the enrollee or patient's Medicaid ID #.
10 – 12 Enrollee Name:	Enter the enrollee for patient's last name, first name and middle initial.
13 – 16 Enclosure Type:	Enter an "X" in the appropriate box to indicate enclosure type.
17. PA Service Type:	Enter the appropriate PA Service Type. (See listing in provider manual.)
18. Comments:	Enter any comments that provide clarification or further information.
19 – 20 Provider Signature & Date	The provider must sign and date the form.