Confidential

Request form for CMH Program Services

DMAS requires any Medicaid Provider submitting Service Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp"

FAX: (804) 612-0045 Phone: (804) 786-1002

1. ☐ New Request ☐ Change Request ☐ Cancel Request ☐ Transfer **Change or Cancel:** enter PA# to be changed or canceled. PA #

2. Date of Request: (mm/dd/yyyy) / /	3. Enrollee Medicaid ID Number (12 Digit #):	4. Enrollee Last Name:	5. Enrollee First Name:	6. Date of Birth: (mm/dd/yyyy) / /	7. Sex: ☐ Male ☐ Female

8. Primary Diagnosis Code/Description:	9. a. NPI/API/Requesting/Service Provider/Case Manager Name & Provider ID Number: b. 9 digit Zip Code (Mandatory)	10. a. NPI/API Referring Provider Name and Provider ID Number: b. 9 digit Zip Code (Mandatory)
1. ____ ____ 2. ____ ____ 3. ____ ____		

11. Justification/Need for Waiver Service Identified on Page 2:

12. Additional Comments (See instructions pertaining to each procedure code):

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Number	13. Procedure Code(National Code)	14. Narrative Description	15. Modifiers (if applicable)	16. Units/ Hrs Requested	17. Frequency	18. Actual Cost per Unit (if applicable)	19. Total Dollar Requested (If applicable)	20. Dates of Service	
								From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.								/ /	/ /
2.								/ /	/ /
3.								/ /	/ /
4.								/ /	/ /
5.								/ /	/ /
6.								/ /	/ /
7.								/ /	/ /
8.								/ /	/ /
9.								/ /	/ /
10.								/ /	/ /

21. **Contact Person Name:** _____

22. **Contact Telephone Number:** _____

23. **Contact Fax Number:** _____

Enrollee Medicaid ID # _____

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INSTRUCTIONS FOR WAIVER ELECTRONIC FAX FORM

www.dmas.virginia.gov

This FAX submission form is required for service requests, and service review for authorization.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via FAX for additional information. Do **not** send attachments for service requests.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject is considered an initial request.
   - **Change**: A change to a previously approved request; the provider may change the quantity of units, dollar amount approved 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, to include the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders when required. **When a provider discontinues services, this is a change.** The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use only to cancel all or some of the items under one service authorization number. Do not use for a discharge or discontinuance of services. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
   - **Transfer**: Use for requesting a transfer of care from one provider number to another.
2. **Date of Request:** The date you are submitting the service authorization request, in mm/dd/yyyy format.
3. **Enrollee Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This is a 12 digit number.
4. **Enrollee Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
5. **Enrollee First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.
6. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
7. **Sex:** Please place a √ or **X** to indicate the gender of the patient.
8. **Primary Diagnosis Code/Description: This is a required field.** Provide the primary ICD-9 diagnostic code and description indicating the reason for service(s). You can enter up to 5 ICD-9 codes and descriptions.
9. **a. NPI/API/Requesting/Service Provider/Case Manager Name and Provider ID Number:** Enter the requesting/service provider name and Provider ID number or national provider identifier (when the NPI is issued).

   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.
10. **a. NPI/API/Referring Provider Name and Provider ID Number:** Enter the referring provider name and national provider identifier or atypical provider identifier for the provider requesting the service.

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

11. **Justification/Need for Requested Waiver Service**

- One of the most important blocks on the form is the need for waiver service. Knowledge of the DMAS criteria/guidelines is necessary to provide pertinent information. **Please refer to the service being requested and include the necessary information. DO NOT ATTACH ASSESSMENTS, PLANS OF CARE, Etc**

Table of Codes and Narrative

National Code /Modifier	Service Category/Description
97139	**Therapeutic Consultation:** *Justification of Need:* Must include objectives, outcomes and the activities conducted and the other waiver services received, including schedules for those services. May NOT include direct therapy, nor duplicate activities available through the state plan. Cannot be solely for the purpose of monitoring.
H2014	**In-home Residential Support:** *Justification of Need must:* Include documentation of the type of specialized supervision authorized, if and why staff presence is required to ensure ongoing or intermittent intervention for the health and safety of the individual. Include documentation of the need for specialized supervision and must include exactly what specialized supervision activities the staff will be performing to include the dates, times, amount and type of services provided. Include documentation of services required and must exceed supports provided by the family or other paid or non-paid caregivers.
S5111	**Family Caregiver Training:** *Justification of Need must:* Include documentation of what the individual's family or caregivers training needs are and how this training is necessary in order to improve the family or caregivers ability to provide care. Include documentation of the name of at least one other billable CMHP service and the name of the individual being trained, for CMHP.
S5135	**Agency Directed Companion Care:** *Justification of Need must:* Include documentation of the name of the PCG, name of the emergency back-up person. Include documentation of how many individuals are sharing hours in the same home. Include documentation of the mental/ orientation status of the individual, name of primary caregiver (PCG) and the hours the PCG works. Also describe the individual's ability/ inability to use the phone. Include documentation of the number of hours per day and the type of services being rendered. Include provider documentation of the type of clear and present danger if the individual is left unsupervised. **NOTE: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and or socialization.**
S5136	**CD-Companion Care:** *Justification of Need must:* See code S5135 in this table above

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S5150	**Consumer-Directed Respite Services:** *Justification of Need must:* Include the name of the unpaid PCG who resides in the same home, the name of the individual directing the care and name of the emergency back-up person.
S5165	**Environmental Modifications: Any request, change, increase, decrease and/or update must be pre- approved by DMAS on the CSP before service authorization can occur.** *Justification of Need must:* Include documentation for the description of the item, cost of materials, labor and must describe the direct medical and/ or remedial benefit to the individual.
99199 U4	**Environmental Modifications – Maintenance: Used when request is for maintenance to a previous approved and purchased item.** *Justification of Need must:* Include documentation for the description of the item, cost of materials, labor and must describe the direct medical and/ or remedial benefit to the individual.
T1005	**Agency Respite Care/Services:** *Justification of Need must:* Include documentation of the name of the unpaid PCG who resides in the same home, name of the emergency back-up person and where the care is provided.

12. **Additional Comments** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the regulations, DMAS manual, and criteria (see Appendix A in DMAS' *Children's Mental Health manual*).
13. **Procedure Code:** Provide the HCPCS/CPT/Revenue/National procedure code. e.g., T1005, S5135, etc.
14. **Narrative Description:** Provide the HCPCS/CPT/Revenue/National procedure code description. e.g., In Home Residential Support, Companion Care, etc.
15. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. This applies only to specific Procedure Codes. See chart above. Example: Environmental Modification - Maintenance, U4 is the modifier.
16. **Units/Hrs Requested**: Based on physician's orders or plan of care provide the number of units/hrs requested. Knowledge of DMAS criteria is necessary. How much of the service is being requested? Example: S5135, Agency Companion Care, 40 hrs. The 40 hrs is the Units/Hrs requested
17. **Actual Cost per Unit (Environmental Modifications Only)**: Enter information in this column for codes identified as needing a cost per unit and are not of a fixed rate.
18. **Frequency**: Enter the frequency of the visits/service from the physician's order or plan of care. (day, week, biweekly {every other week}, month, year)
19. **Total Dollars Requested (Environmental Modifications Only)**: If applicable, enter the dollar amount requested for items listed. All EM codes combined can not exceed $5,000.00 in a calendar year. *(Effective January 1, 2011 All EM codes combined can not exceed $3,000.00 in a calendar year.)
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 Phone 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, or if additional information is needed to complete the request.

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Note: Incomplete data may result in the request being rejected or denied; therefore, it is very important that this form be completed as thoroughly as possible with the pertinent information.

The purpose of service authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.