# Transplants Service Authorization Request Form
## Virginia Department of Medical Assistance 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***

**Submit fax request for Service Authorization to: 804-452-5450**

**Submit requests at least 30 days prior to scheduled date of procedures/services**

1. ☐ Original ☐ **Cancel** ☐ **Change** **Recert: Enter previous SRV AUTH#. Change or Cancel: enter SRV AUTH# to be changed or canceled. SRV AUTH #**

| | | | | |
|---|---|---|---|---|
| 2. **Date of Request (mm/dd/yyyy)** / / | 3. **Review Type (check one if applicable)**<br>☐ Retrospective Prepayment Review (Date notified of eligibility / / )<br>☐ Retroactive MCO disenrollment | | | |
| 4. **Member Medicaid ID Number** (12 digit Number): | 5. **Member Last Name**: | 6. **Member First Name:** | 7. **Date of Birth** (mm/dd/yyyy): / / | 8. **Gender:**<br>☐ Male<br>☐ Female |
| 9.<br>a. **NPI/API/Requesting Service Provider Name & ID Number:**<br>b. **9 digit Zip Code (Mandatory)** | 10. **Treatment Setting**<br>☐ Inpatient | 11. **Primary Diagnosis Code/ Description: (enter up to 5)**<br>1. 2.<br>3. 4.<br>5. | | |
| 12.<br>a. **NPI/API/Referring Provider Name and ID Number:**<br>b. **9 digit Zip Code** ***(Mandatory)*** | 13. **SRV AUTH Service Type:**<br>☐ 0300 Organ or Stem Cell Transplant | | | |
| 14. **Severity of Illness (See instructions pertaining to each SRV AUTH service type):** | | | | |
| 15. **Intensity of Services (See instructions pertaining to each SRV AUTH service type):** | | | | |
| 16. **Additional Comments (See instructions pertaining to each SRV AUTH service type):** | | | | |

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| Number | 17. HCPCS/ CPT Code | 18. Code Description | 19. Modifiers (if applicable) | 20. Units Requested | 21. Dates of Service | |
|---|---|---|---|---|---|---|
| | | | | | From (mm/dd/yyyy) | Thru (mm/dd/yyyy) |
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| 17. | | | | | / / | / / |
| 18. | | | | | / / | / / |

22. **Contact Name:**

23. **Contact Telephone Number:**

24. **Contact Fax Number:**

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## INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This fax submission form is required for service authorization of all organ or stem cell transplants. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via fax for additional information. Submit your request using this DMAS 3511 form.. Include attachments as necessary.

Final approval is contingent upon passing member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be sent to you via U.S. mail process and will be available to providers through the Automated Response System or Medicall system within 24 hours (or the next business day) if reviewed and approved. Please refer to the Virginia Medicaid *Provider* Manuals, Chapter I, page 18, *General Information*, for instructions on how to access these systems.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous Service 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.
   - **Cancel**: Use to cancel all or some of the items under one Service Authorization number. An example of canceling all lines is when an authorization is requested under the wrong member number.
2. **Date of Request:** The date you are submitting the Service 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. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the member's Medicaid number is valid. This should contain 12 numbers.
5. **Member Last Name:** Enter the member's last name exactly as it appears on the Medicaid card.
6. **Member First Name:** Enter the member'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 a √ or **X** to indicate the sex of the member.

9. **a. NPI/API Requesting/Service Provider Name and ID Number:** Enter the requesting/service provider name and ID number, national provider identifier or atypical provider identifier.

   **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.

10. **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/API Referring Provider Name and ID Number:** Enter the referring provider name and ID number, national provider identifier or atypical provider identifier for the provider requesting 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/API number being submitted.

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

14. **Severity of Illness (Patient criteria):** Submit complete Pre-Transplant evaluations.to include the chief complaint, history of present illness, pertinent past medical history, supportive diagnostic studies, labs, imaging, EKG, and other diagnostic modalities to substantiate the need for the transplant. Refer to the DMAS *Hospital* or *Physician/Practitioner* Manuals, Appendix D, *Transplant Surgery* for specific criteria. Attach documentation to this request as needed. Knowledge of InterQual/DMAS criteria will be extremely helpful.

15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services):**

    Provide the treatment plan for the member. List the services, procedures, or treatments that will be provided to the member. Knowledge of InterQual/DMAS criteria will be extremely helpful

    Describe the surgeon's and the facility's experience with this type of transplant.

16. **Additional Comments:** This area is 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 InterQual criteria (see SRV AUTH chapter in the DMAS Manuals).

17. **HCPCS/CPT Code:** Provide the HCPCS/CPT procedure code.

18. **Code Description:** Provide the HCPCS/CPT/procedure code description.

19. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable.

20. **Units Requested**: Based on physician's orders, plan of care, or CMN, provide the number of services requested. Knowledge of InterQual/DMAS criteria will be extremely helpful. Enter numbers only in the Units Requested block.

21. **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.

22. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax.

23. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
24. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

**Incomplete data may result in the request being denied; therefore, it is very important that this form be completed with all the pertinent medical/clinical 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 Member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.**