

Inpatient Service Authorization Request Form
DMAS/Acentra Health

Additional Information

21. Severity of Illness:

22. Intensity of Services:

23. Additional Comments (See Instructions):

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INSTRUCTIONS FOR ELECTRONIC FAX FORM

vamedicaid.dmas.virginia.gov/sa
www.dmas.virginia.gov

This FAX submission form is required for inpatient Rehabilitation Service Authorization Review, Admission, Concurrent Review and Retrospective Review. 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. Only information provided on **KEPRO** forms can be entered. Do **not** send attachments or non-**KEPRO** forms.

If KEPRO determines that your request meets appropriate coverage criteria guidelines the request will be “tentatively approved” and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining Member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program Atrezzo Connect (vamedicaid.dmas.virginia.gov/sa) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS’ Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a or **X** in the appropriate box.
 1. **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
 2. **Recertification:** A request for continued services (items) beyond the expiration of the previous service authorization would be a recertification request.
 3. **Change:** a change to a previously approved request; the provider may change the notes fields. The provider may not submit a “change” request for any item that has been denied or is pending.
 4. **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 Retrospective review policy and procedure for each service detailed information regarding the submission of a Retrospective Review request. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.

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4. **a. Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 12 numbers.
b. Eligibility: Identify the Members Eligibility Medicaid FFS or Medicaid Expansion. It is the provider's responsibility to check Member's Medicaid eligibility prior to Service Authorization submittal.
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. **Sex:** Please place a or **X** to indicate the sex of the patient.
9. **a. NPI/API Submitting Provider Name:** Enter national ID number or atypical provider identifier; Enter the requesting physician's name
b. Medicaid ID Number: Medicaid ID number
c. 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. **a. NPI or API/Facility Name:** Enter the name and Medicaid Identification number, national provider identifier or atypical provider identifier of the hospital where the physician is requesting that the patient be admitted.
b. Medicaid ID Number: Medicaid ID number
c. 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. **Treatment Setting:** Place a or **X** to indicate the place of service.
12. **Admission Date:** Indicate the planned admission date using the mm/dd/yyyy format.
13. **Admission Status:** Place a or **X** for Urgent/Elective admission. This refers to the clinical status of the patient that is being admitted.
14. **Primary Diagnosis Code/Description:** Provide the **primary diagnosis code and description** indicating the reason for admission. You can enter up to 5 admission descriptions. For dates of service 10/1/2015 and beyond, please use the appropriate ICD-10 code.
15. **Number of days requested:** Based on your judgment provide the number of days requested for this admission diagnosis. Knowledge of InterQual/DMAS criteria will be extremely helpful.
16. **Attending Physician Medicaid ID Number/NPI:** Provide the Attending Physician's Medicaid ID number or national provider identifier.
17. **SRV AUTH Service Type:** Place a or **X** to indicate Intensive Rehabilitation

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<i>Out of State for Inpatient Rehabilitation</i>	<p>Out of state providers, located close to the proximity of the VA State line and who are enrolled with Virginia Medicaid as a provider class type 085 (Out of State Rehab Hospital) need to determine and document evidence that one of the following items are met at the time the service authorization request is submitted to the service authorization contractor</p> <p>Services provided out of state for circumstances other than these specified reasons shall not be covered.</p> <ol style="list-style-type: none"> 1. The medical services must be needed because of a medical emergency; 2. Medical services must be needed and the member's health would be endangered if they were required to travel to his/her state of residence; 3. The state determines, on the basis of medical advice , that the needed medical services, or necessary supplementary resources; are more readily available in the other state; 4. It is the general practice for the members in a particular locality to use medical resources in another state 5. In what state will this service be performed? 6. Can this service be provided by a provider in the state of Virginia? <ol style="list-style-type: none"> a. If no, what is the medical reason why it cannot be provided in Virginia?
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18. Severity of Illness (Clinical indicators of illness including abnormal findings)*: One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information. Provide the clinical information of chief complaint, history of present illness, pertinent past medical history and previous treatment to substantiate the need for hospitalization and level of service for the requested admission/procedure. This field must include pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities. Include supportive diagnostic outpatient procedures and abnormal finding on physical examination. This information also assists the reviewers in further assessing the patient's condition. (Always include dates, types & results [with dimensions/% as appropriate]).

19. Intensity of Services (Proposed/Actual monitoring and therapeutic services)*: This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be

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helpful to provide pertinent information. This field must include the treatment plan for the patient while in the facility. List the services, procedures, or treatments that will be provided to the patient while in the facility.

20. **Additional Comments:** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the length of stay. For example, if a patient has been treated several times as an outpatient and failed therapy or has not followed through on treatment, then information of this sort should be placed here..
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.

****Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with 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.

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