



CONFIDENTIAL

Home and Community Based Services Request Form

ALL FIELDS REQUIRED

Health Plan Fax #:		Health Plan Phone #:		
1. <input type="checkbox"/> New Request		Change Request		
2. Date of Request (mm/dd/yyyy) / /	3. Member Phone Number:			
4. Member Medicaid ID (12 digits):	5. Member Last Name:	6. Member First Name:	7. <input type="checkbox"/> Date of Birth (mm/dd/yyyy) / /	8. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
9. Service Provider Information		10. Primary Diagnosis Code/Description:		
a. Service Provider Name:		a.		
b. NPI/API Provider ID Number:		b.		
c. Provider Street Address and City		c.		
d. 9 digit zip code: (required)		d.		
11. Additional Information (if any)		12. Service Authorization Type:		
		<input type="checkbox"/> 0900-CCC Plus Waiver (members not receiving PDN) <input type="checkbox"/> 0960-CCC Plus Waiver (members receiving PDN) <input type="checkbox"/> 0090- EPSDT Private Duty Nursing	<input type="checkbox"/> 0091- EPSDT Personal/ Attendant Care <input type="checkbox"/> 0092 EPSDT Assistive Technology <input type="checkbox"/> 0098- EPSDT Private Duty Nursing in School- MCO	
13. Justification/Need for Service Requested:				

The information contained in this facsimile is legally privileged and confidential information intended only for the use of the entity named above. If the reader of this message is not the intended member, or the employee or agent responsible for delivering this communication in error, please notify DMAS by telephone or FAX at the appropriate number listed above and destroy the misdirected document. Thank you.



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

Member Last Name:		Member First Name:				Member Medicaid ID Number:		
15. Procedure Code (National Code):	16. Narrative Description:	17. Modifiers (If Applicable)	18. Units/Hours Requested	19. Frequency	20. Actual Cost per Unit (if applicable)	21. Total Dollar Requested (if applicable)	22. Dates of Service	
							From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Provider Contact Person:		24. Provider Contact Phone Number:				25. Provider Contact Fax Number:		

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INSTRUCTIONS FOR FAX FORM

Web Resources: www.dmas.virginia.gov

This FAX submission form is required for Home and Community Based service requests for review. Supporting documentation is required

Please be certain that all information blocks contain the requested information. Incomplete information may result in the case being rejected or returned via FAX for additional information. For EDCD Waiver enrollment requests only, send pertinent documents needed for enrollment.

1. **Request type:** Place a ✓ or X in the appropriate box.
 - a. **New:** Use for all new requests.
 - b. **Change:** Use to make 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 and not 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 submitted as a change.** The provider may not submit a “change” request for any item that has been denied.
2. **Date of Request:** Request in MM/DD/YYYY format.
3. **Member Phone Number:** Please provide the member’s (or authorized representatives) phone number, including area code. If none, indicate N/A.
4. **Member Medicaid ID Number:** It is the Provider’s responsibility to ensure the Member’s Medicaid number is valid prior to initiating this request. This is a 12 digit number.
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:** Must be in the MM/DD/YYYY format (for example, 02/25/2004).
8. **Gender:** Please place a ✓ or X to indicate the gender of the Member.
9. **Complete the following:**
 - a. **NPI/API Service Provider Name:** Enter the name of the Provider who is providing the service.
 - b. **Provider ID Number:** Enter the National Provider Identifier (NPI).
 - c. **Provider Street Address and City:** Enter the street address and city of the provider.
 - d. **9- digit zip code:** Enter the 9-digit zip code **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).
10. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).
11. **Additional Information (if any):** Space for providers to give additional information



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12. **Service Authorization Type:** Check the box for the program that the service will be provided under
13. **Justification/Need for Requested Waiver Service:** Knowledge of the DMAS criteria/guidelines are required to provide pertinent information. Refer to the service being requested and include the necessary information.
14. **Additional Comments:** Used for further information and other considerations and circumstances to justify the 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 Chapter IV in the appropriate DMAS manual).
15. **Procedure Code:** Provide the HCPCS/CPT/National procedure code (For example, T1019, S5126, etc.)
16. **Narrative Description:** Provide the HCPCS/CPT/ National procedure code description. (For example, Personal Care, Consumer Directed Personal Care, etc.)
17. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. This applies only to specific Procedure Codes.
18. **Units/Hours Requested:** Based on physician's orders or Plan of Care provide the number of units/hours requested. Knowledge of criteria will be extremely helpful. How much of the service is being requested? Example: S5126, CD Personal Care, 30 hours/ week. The 30 hours is the Units/hours requested.
19. **Actual Cost per Unit (Assistive Technology or Environmental Mods Only):** Enter information in this column for codes identified as needing a cost per unit.
20. **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)
21. **Total Dollars Requested (Assistive Technology and Environmental Mods, Only):** If applicable, enter the dollar amount requested for items listed. All AT/EM codes combined cannot exceed \$5,000.00 in a calendar year.
22. **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.
23. **Provider Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.
24. **Provider Contact Phone Number:** Enter the phone number with area code of the Provider contact name.
25. **Provider Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject, a need to request additional information, insufficient (demographic) information, or to send a General Provider Letter via fax.

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 criteria for reimbursement. Service Authorization does not automatically guarantee payment for service; payment is contingent upon passing all edits contained within the claims payment process, the Member's continued Medicaid and MCO eligibility, and the ongoing medical necessity for the service being provided.