



Prior Authorization Request

MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Providers must complete items 1-21 or risk delays.

PROVIDER INFORMATION SECTION

MEMBER INFORMATION SECTION

1. Provider's Name, Address, and Tel. No.				4. Member's Name, Address, and Tel. No.				5. Place of Residence			
								<input type="checkbox"/> Home <input type="checkbox"/> Nursing facility <input type="checkbox"/> Rehab. Hospital <input type="checkbox"/> Other: _____			
								6. Height		7. Weight	
								ft	in	lb	oz
2. Provider ID/Service Location or NPI				8. Gender	9. Other Insurance		10. Full Name of Insurance Carrier				
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No						
3. PA Assignment				11. Date of Birth		12. Member ID					
				/ /							
13. Explain why this service is medically necessary. Include the diagnosis, place of service, and a description of the proposed treatment. Attach supporting documentation if required by MassHealth regulations.											
Primary Diagnosis						Secondary Diagnosis					
Diagnosis Code(s)						Place of Service					
Description of Treatment											

SERVICES REQUESTED

MASSHEALTH USE ONLY (ITEMS 22-38)

14. Servicing Provider ID/Service Location or NPI	15. Service Code (Use a separate line for each code.) Include modifier if code requires one.	16. No. of Units (Enter at least 1.)	23. Reviewer Decision	24. Revised Service Code (or Range)	25. No. of Units	26. Duration (Days)	27. Unit Fee	28. Denial Reason No.	
A			<input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Denied						
B			<input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Denied						
C			<input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Denied						
D			<input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Denied						
E			<input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Denied						
17. Attachments		18. Date PA Requested		29. Receipt Date		30. Deferral Date		31. Date Info Received	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		/ /		/ /		/ /	
19. Requested Effective Date		20. Requested End Date		32. Authorized Effective Date		33. Authorized End Date		34. Decision Date	
/ /		/ /		/ /		/ /		/ /	
21. Provider Signature				35. Consultant Initials			36. Consultant ID		
I certify that I am the provider identified on this form. I certify that the information provided on this form and on any attachments, including medical necessity information (per 130 CMR 450.204) is true, accurate, and complete to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.									
				37. Tracking Number					
22. Comments for reason of denial, modification, or deferral (MASSHEALTH USE ONLY)				38. PA Number					
				P					

Please see reverse side for instructions.

INSTRUCTIONS FOR COMPLETING THE PA-1 FORM (PLEASE PRINT OR TYPE.)

General Instructions

Complete Items 1 - 21 only. Enter all dates in mm/dd/yyyy format. Below are instructions for specific fields. All other fields are self-explanatory.

(A) Provider Information Section

Item 1	Provider's Name, Address, and Tel. No.	Enter the provider's name, address, and phone number (including area code).			
Item 2	Provider ID/Loc or NPI	Enter the nine-digit requesting provider ID followed by the one-character location code. If not available, enter the requesting provider's 10-digit national provider identifier.			
Item 3	PA Assignment	<p>Select the type of PA you are requesting from the following list.</p> <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 33%;"> Basic Medical Medical Pharmacy DMR PCA Services PCA Services Pediatric PCA Services PERS Physician-Adult Physician-Pediatric Private Duty Nursing Skilled Nursing Vision Other </td> <td style="vertical-align: top; width: 33%;"> Durable Medical Equipment Absorbent Products DME - Other Enterals Hearing Services Mobility and Repairs Orthotics and Prosthetics Oxygen Standers </td> <td style="vertical-align: top; width: 33%;"> Therapy Services Occupational Therapy Physical Therapy Speech/Language Therapy </td> </tr> </table>	Basic Medical Medical Pharmacy DMR PCA Services PCA Services Pediatric PCA Services PERS Physician-Adult Physician-Pediatric Private Duty Nursing Skilled Nursing Vision Other	Durable Medical Equipment Absorbent Products DME - Other Enterals Hearing Services Mobility and Repairs Orthotics and Prosthetics Oxygen Standers	Therapy Services Occupational Therapy Physical Therapy Speech/Language Therapy
Basic Medical Medical Pharmacy DMR PCA Services PCA Services Pediatric PCA Services PERS Physician-Adult Physician-Pediatric Private Duty Nursing Skilled Nursing Vision Other	Durable Medical Equipment Absorbent Products DME - Other Enterals Hearing Services Mobility and Repairs Orthotics and Prosthetics Oxygen Standers	Therapy Services Occupational Therapy Physical Therapy Speech/Language Therapy			

(B) Member Information Section

Item 4	Member's Name, Address, and Tel. No.	Enter the member's name, address, and phone number (including area code).
Item 13	Explain why this service is medically necessary Diagnosis Code(s) Place of Service Description of Treatment	Enter a statement explaining why the proposed service is medically necessary. Include the primary diagnosis and secondary diagnosis if there is one. Also include a description of the proposed treatment and prognosis. Refer to your MassHealth provider manual for additional information about this field. Enter the ICD diagnosis code(s) for the most relevant diagnoses for the procedure or item being requested. Enter the location of service. Enter a narrative of the proposed treatment.

(C) Services Requested Section

Item 14	Servicing Provider ID/Service Location or NPI	Enter the nine-digit servicing provider ID followed by the one-character service location code. Write "same" if same as requesting provider ID/Service Location. If not available, enter the provider's 10-digit national provider identifier.
Item 15	Service Code	Enter the appropriate CPT or HCPCS code for each service requested. Refer to Subchapter 6 of the applicable MassHealth provider manual to determine payable service codes. You must include a modifier if the service code requires one.
Item 16	No. of Units	Enter the number of times the service for which you are requesting prior authorization will be furnished. At least "1" must be entered.

(D) Attachments and Signature

Item 17	Attachments	Select the "Yes" box if additional information or supporting documentation is attached (refer to your provider manual); otherwise select the "No" box. Be certain that the attached documentation clearly supports the medical necessity for the services and/or equipment you are requesting (for example, X rays, admission notes, photographs, or explicit details).
Item 21	Provider Signature	The form must be signed by the provider or the individual designated by the provider to certify that the information entered on the form is correct. Signatures other than handwritten (that is, typewritten, or those by stamp or data processing equipment) are acceptable.

(E) MassHealth Use Only

Items 22 - 38	Leave these items blank.	MassHealth completes Items 22 - 38 when it reviews the request for prior authorization. Leave these fields blank.
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See Subchapter 5 of your MassHealth provider manual for additional instructions for requesting prior authorization.

INSTRUCTIONS FOR MAILING REQUESTS FOR PRIOR AUTHORIZATION

Mail the Prior Authorization Request form, together with all necessary attachments, to:

MassHealth
 ATTN: Prior Authorization
 100 Hancock Street, 6th Floor
 Quincy, MA 02171