NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____
Dates of Service: _____
EPSDT: _____SA #: _____

REQUEST FOR SERVICE AUTHORIZATION

FOR DURABLE MEDICAL EQUIPMENT (DME)

(Fee-for-Service (FFS) Program Only - **Not** for Managed Care program use)

Instructions for filling out this form are attached.

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS CODES: _____

ALTERNATE INSURANCE: NAME OF PLAN _____

PROVIDER INFORMATION

DATE(S) OF REQUEST: _____ CONTACT PERSON: _____

TELEPHONE: _____ FAX #:_____

PROVIDER NAME #: _____ PROVIDER MEDICAID ID #: _____

DOCUMENTATION OF FACE TO FACE ENCOUNTER: Pursuant to He-W 571.05(h) A Provider shall conduct and document a face-to-face encounter with the recipient no earlier than 60 days prior to submitting a Service Authorization request and the Provider's written order shall include the date of the encounter and the primary clinical reason the recipient needs the item(s).

PHYSICIAN'S ORDER: Pursuant to He-W 571.05 (a)(c)(d) a prescription shall be written by the NH licensed Provider including name, date of birth, address, Medicaid number and details of use of equipment.

LETTER OF MEDICAL NECESSITY: Pursuant to He-W 571.05(b)(c)(d) a signed letter of medical necessity shall be written by the NH licensed Provider for the below requested DME, including name, date of birth, Medicaid number, a written diagnosis, anticipated length of use and supporting clinical documentation.

MOBILITY EVALUATION FORM AND NON-WHEELCHAIR EVALUATION FORM: Pursuant to He-W 571.05(c), requests for all wheelchairs, scooters, and customized strollers must also include a completed Form 272M, "Mobility Evaluation Form" Pursuant to He-W 571.05(e), requests for all standers, gait trainers, and bath and toileting items shall also include a completed Form 272EQ, "Medical Equipment Request Evaluation Form Non-Wheelchair"

For the items listed below: (*PLEASE CHECK BOXES TO THE LEFT AND INCLUDE ALL IN FAX.)**

- ☐ I certify that I have obtained and have on file a Face-to-Face documentation pursuant to He-W 571.05(h).
- ☐ I certify that I have attached a Physician's order and a LMN pursuant to He-W 571.05(d).
- ☐ I certify that items listed will be provided and that the documentation regarding our acquisition costs reflects best price (Usual and customary pursuant to Section 126-A:3).
- ☐ The Mobility Evaluation form is attached or the Medical Equipment Request Form is attached.

_____

Signature of DME Provider ***Date***

_____

Printed Name ***Title***

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

PLEASE LIST ALL DME PRODUCTS BEING REQUESTED ON PAGE 2

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL

129 Pleasant St ■Concord, NH 03301 ■FAX: (603) 271-8194

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DME ORDERED

You must indicate all costs for each item listed. Use a separate form for additional items

ORDER INFORMATION									
Recipient Name:					**DOB:**	**Medicaid #:**			
Equipment Requested	**Procedure Code**	**Modifier**	**# of Units**	**Acquisition Cost per unit**	**Manufacturer's suggested retail per unit**	**Monthly rental charge**	**Date(s) of Service**		**FOR STATE USE ONLY APPROVED AMOUNT**
							START	**END**	

*****CLINICAL INFORMATION (must be included with submission):*****

Please attach physician's order and all clinical notes to support the medical necessity for the item(s) requested.

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INSTRUCTIONS FOR DURABLE MEDICAL EQUIPMENT:
FORM 272D FFS REQUEST FOR DURABLE MEDICAL EQUIPMENT

Please do **NOT** send instructions in with your request.

Note that before this form is filled out, **it is your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Note if there is an Alternate Insurance, NH Medicaid is the payer of last resort. We will need an Explanation of Benefit from the primary insurance company or a denial letter in order to process your request.

The section following is the legal information with references to the Medicaid rule, for your convenience. Note that you are **now required to attest, by signature**, that you have the Face to Face documentation in your possession. The signature should be that of the provider performing the services. **Also note that we cannot process any wheelchairs, scooters, customized strollers, standers, gait trainers, and bath and toileting items without the 272M FFS Mobility Evaluation Form Wheelchair or 272EQ FFS Non-Wheelchair Evaluation Form attached pursuant to He-W 571.05(c) and He-W 571.05(e).

The next section, page 2, is the equipment you are requesting. Fill in a description of the DMEs, the Procedure Code and an RR modifier if it is a rental, the number of units, the acquisition cost **per unit,** the manufacturer's suggested retail **per unit (we cannot process without the cost information),** the monthly rental charge **per unit,** and the start and end date of service. **Note that proof of your costs must be attached.

Attach the Physicians order, the Face-to-Face medical record, the Letter of Medical Necessity, proof of your cost, the Mobility Evaluation, if required and clinical notes supporting the request.

Fax all documentation and the SA form to 603-271-8194. You will receive a fax from the state with the approval information or a request for more information. Once the SA has been approved by the State it is sent to the Fiscal Agent, Conduent, to create the authorization. Conduent has three business days to create and mail the authorization to the performing provider. If you have questions, please call Conduent at 1-866-291-1674.