Government of the District of Columbia
Department of Health Care Finance
Fee-For-Service Medicaid Program

719A Prior Authorization Request

Patient			Prescribing Provider		Servicing Provider	
Beneficiary Name JOHN DOE			Provider Name JOHN Doctor		Provider Name DME Provider	
DCID Number 77000000			Provider Number 0888888	NPI 1888877777	Provider Number 07777788	NPI 1555566666
Address City, State, Zip 5555 DC Street, NE Washington, D.C. XXXXX			Address City, State, Zip 44333 Nursing Home Road, NE Washington D.C. XXXXX		Address City, State, Zip 12000 Brown Road, NE Washington D.C. XXXXX	
Telephone Number 202-XXX-XXXX	DOB XX/XX/XXXX	SEX X	Telephone Number 202-XXX-XXXX		Telephone Number 202-XXX-XXXX	
Other Health Insurance Coverage			Requested Service		Beneficiary Location	
			Surgery ☐	DME ☒	Home ☐	
			Medical ☐	Pharmacy ☐	ICF/MR ☐	
			Dental ☐	Eyewear ☐	Nursing Home ☒	
			Hospice ☐	Other ☐	Hospital ☐	
Discharge Date:			Home Health: ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Duty		Office ☐	

Requested Service Data

Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges
Use ICD-10	T4521	Adult Size Brief	6 months	1260	$2240.00
Code for Dx.	A4554	DISPOSABLE UNDERPADS, ALL SIZES, E.G., CHUX	6 months	1800	$2350.00
N39.41					
G82.22					

Justification: e.g. patients have spinal cord injury, resulting in chronic urinary incontinence due to neurogenic bladder. Conservative measures have been attempted or are not sufficient due to the patient's medical and functional limitations. The condition is permanent and requires ongoing use of incontience supplies to maintain hygiene, protect skin integrity, and prevent complications such as infection.

For Dental Use only

DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY"?", X-RAYS TAKEN BY "V"

Q1				FACIAL								FACIAL				Q2
01	02	03		04	05	06	07	08	09	10	11	12	13	14	15	16
R																L
I			PRIMARY TEETH	A	B	C	D	E	F	G	H	I	J	PRIMARY TEETH		E
G				LINGUAL								LINGUAL				F
H				T	S	R	Q	P	O	N	M	L	K			T
T																
32	31	30		29	28	27	26	25	24	23	22	21	20	19	18	17
Q4				FACIAL								FACIAL				Q3

For DME, Home Health, Private Duty Use Only

Requesting Physician Certification: I certify that I have documented that a Face-to-Face encounter, related to the primary reason the beneficiary requires Home Health or DME services, occurred on _____ between the beneficiary and the allowed prescriber (listed below).

☐Primary Physician ☐ Nurse Practitioner ☐ Certified Nurse Mid-Wife ☐ Physician Assistant ☐ Acute or Post-Acute Physician

Name of allowed prescriber:_____ Title:_____ Date:_____

Durable Medical Equipment Face to Face Regulations

☐ **Any HCPCS code for the following types of DME:** ++Transcutaneous Electrical Nerve Stimulation (TENS) unit ++Rollabout Chair ++Traction-cervical ++Oxygen and Respiratory equipment ++Hospital beds and accessories

☐ Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than $1,000.

☐ Any other item of DME that CMS adds to the list of Specified Covered Items

Signature of the Requesting Provider: I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete.

Signature:_____John Doctor_____ Title:_____Title of the requesting physician/ practioner_____ DATE 5/27/2026