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 Home Health Agency	
DCID Number 70000000			Provider Number 0xxxxxxx	NPI 1xxxxxxxxxx	Provider Number 0xxxxxxx	NPI 1xxxxxxxxxxx
Address City, State, Zip 55 Patient St, NE Washington, DC 2xxxx			Address City, State, Zip 4xxxx Dr. RD Washington, DC 2xxxx		Address City, State, Zip 12 Home Health Rd Washington, DC 2xxxxx	
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	X
	Medical	☐	Pharmacy	☐	ICF/MR	☐
	Dental	☐	Eyewear	☐	Nursing Home	☐
	Hospice	☐	Other	☐	Hospital	☐
Discharge Date:	Home Health: XSkilled 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
	G0300	SKILLED NURSING FOR 1 HOUR, TWICE DAILY X 7 DAYS/WEEK X 60 DAYS	60 DAYS	480	
F79.9		MENTAL RETARDATION			
F31.6		BIPOLAR DISORDER			
C34.9		MALIGNANT NEOPLASM			

Justification: PATIENT HAS DIAGNOSIS OF BIPOLAR DISORDER, MENTAL RETARDATION, SEVERE PROTEIN MALNUTRITION, MALIGNANT NEOPLAMS AND REQUIRES SKILLED NURSING FOR MEDICATION MANAGEMENT FOR 1 HOUR, TWICE DAILY. THE CURRENT REQUEST IS FROM 09/01/21 TO 10/31/2021.

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	PRIMARY TEETH	04	05	06	07	08	09	10	11	12	13	PRIMARY TEETH	14	15	16
RIGHT				A	B	C	D	E	F	G	H	I	J				LEFT
				LINGUAL								LINGUAL					
				T	S	R	Q	P	O	N	M	L	K				
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 John Doctor between the beneficiary and the allowed prescriber (listed below).

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

Name of allowed prescriber: John Doctor Title: PMP Date: xx/xx/xxx

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: PMP

DATE xx/xx/xxxx