

# Medical Assistance Program Prior Authorization Request (PAR) Form

Long Term Home Health  Private Duty Nursing  EPSDT Extraordinary HH

Revision? Yes  No  Effective Date of Revision: \_\_\_\_\_ PAR Number being revised: \_\_\_\_\_  
Use original PAR number

**Please provide supporting documentation with this form. \* See instructions on the reverse side of form.**

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Client Birth Date: \_\_\_\_\_ Client Medical Assistance Program ID #: \_\_\_\_\_ County Number: \_\_\_\_\_

PAR Start Date: \_\_\_\_\_ PAR End Date: \_\_\_\_\_

Service(s) Requested Clients Age 18, 19, 20:  Single Entry Point/HCBS eligible  Not HCBS Eligible

Check Appropriate Program <input type="checkbox"/> Home Health <input type="checkbox"/> EPSDT HH	Specify Order	Units Requested	Place of Service (EPSDT)	Revenue Code	Unit Reimb Rate	Over Daily Max Amt (✓)	Units Authorized	Total Amount Authorized	Approved (A) Pended (P) Denied (D)
HH RN LPN				551	95.04				
Brief Nursing Visit-1				590	66.52				
Brief Nursing Visit- 2+				599	46.57				
CNA Basic				571	33.80				
CNA Extended				579	10.11				
PT – Only for EPSDT HH or Children under 21 in LTHH				421	103.93				
OT – Only for EPSDT HH or Children under 21 in LTHH				431	104.61				
ST – Only for EPSDT HH or Children under 21 in LTHH				441	112.94				

	Specify Order	Units Requested	Revenue Code	Unit Reimb Rate	Units Authorized	Total Amount Authorized	Approved (A) Pended (P) Denied (D)
<b>Private Duty Nursing</b>							
PDN RN			552	37.55			
PDN LPN			559	28.19			
RN Group			580	28.13			
LPN Group			581	21.59			
RN/LPN Blended			582	28.11			

Requesting Agency & Representative Signature:	Provider ID:
SEP Agency ID, if appropriate:	Provider's Local Phone Number:
Narrative Information:	
Denial Reason Codes:	
Signature of Authorizing Party:	Date PAR processed:

## PAR Completion Instructions

Complete this form for Prior Authorization Requests for Private Duty Nursing, Long Term Home Health, and EPSDT Extraordinary Home Health. Submit appropriate documentation to support your request including detailed demographics, diagnosis, physician's orders, treatment plans, medications, etc.

Acceptable documentation includes a complete CMS-485 form, MD orders, and Admission paperwork for PDN and EPSDT HH.

Complete the Revision section at the top of the form *only* if you are revising a current approved PAR.

### **Remember**

*For LTHH PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.*

*At the top of the form - Check the box in front of your program.*

### **Complete the following fields**

Client Name - Required

Client Medical Assistance Program ID number - Required

County Number - Required

Date - Required

PAR start date - Required

PAR end date - Required

**Check either** Single Entry Point/HCBS eligible **or** Not HCBS Eligible

**Check the type of program** (HH, EPSDT) for which you are requesting services.

**Enter the number of units** next to the services for which you are requesting reimbursement.

Do *not* enter anything to the right of the double vertical line. This is for the authorizing agency use only.

### **Complete the following**

Enter your agency name - Required

Sign your name - Required

Enter the Medical Assistance Program Provider ID number - Required

Enter the SEP provider ID - *Only as appropriate for revisions.* The SEP will complete this portion for all others when appropriate.

Narrative information - Home Health Agencies may use this field to explain the reasons for requested frequency, duration, medical necessity, or by SEP to explain reasons for denial or approval of a reduced amount, as needed.

### **Do not write in the following sections**

Denial Reason Codes - Authorizing agent use only.

Signature of Authorizing Party - Authorizing agent use only.

Date PAR processed - Authorizing agent use only.

Submit PARs and supporting documentation to the appropriate authorizing agent listed below.

LTHH PARS	PDN PARS	EPSDT HH PARS
Send to:	Send to:	Send to:
The SEP in the client's county of residence <b>OR</b> The fiscal agent (ACS) if under 21 years old and not HCBS eligible	<b>Ascend Management Innovations LLC (Ascend)</b> <i>(Formerly called DDM)</i>	<b>Colorado Foundation for Medical Care</b>
<b>PARs</b>	227 French Landing Drive, Ste 250 Nashville, TN 37228	23 Inverness Way East, Ste 100 Englewood, CO 80012-5700
PO Box 30	Fax: 877-431-9568	Fax:303-695-3377
Denver, CO 80201-0030		