

WISCONSIN MEDICAID PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services. The use of this form is mandatory when requesting PA for durable medical equipment (DME).

INSTRUCTIONS: Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested equipment or supplies. If necessary, attach additional pages for the provider's responses and/or an occupational or physical therapy report if available. All DME, including repairs, must be prescribed by a physician. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements.

Attach a photocopy of the physician's prescription to the completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA). The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid. Attach the PA/DMEA to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial.

Element 2 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System to obtain the correct identification number.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Prescribing Physician

Enter the name of the prescribing physician.

Element 5 — Prescribing Physician's Medicaid Provider No.

Enter the eight-digit Medicaid provider number of the prescribing physician. The provider number in this element must correspond with the provider name listed in Element 4.

Element 6 — Telephone Number — Prescribing Physician

Enter the prescribing physician's telephone number, including area code.

Element 7 — Telephone Number — Dispensing Physician

Enter the dispensing physician's telephone number, including area code.

SECTION III — SERVICE INFORMATION

Element 8

Describe the overall physical status of the recipient (mobility, self-care, strength, coordination).

Element 9

Describe the medical condition of the recipient as it relates to the equipment/item requested. Indicate why the recipient needs this equipment.

Element 10

Indicate if the recipient is able to operate the equipment/item requested.

Element 11

Indicate if the training is provided or required.

Element 12

State where equipment/item will be used. Describe type of dwelling and accessibility.

Element 13

State estimated duration of need.

Element 14

If renewal or continuation of DME authorization is requested, describe the following about the recipient, including current clinical condition, progress (improvement, no change, etc.), results, and the recipient's use of equipment/item prescribed.

Element 15

Indicate amount of oxygen to be administered.

Element 16 — Signature — Requesting Provider

Enter the signature of the requesting provider.

Element 17 — Date Signed

Enter the month, day, and year the PA/DMEA was signed (in MM/DD/YYYY format).

Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid.