

Arkansas Foundation for Medical Care, Inc.
PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT
EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER					
<input type="checkbox"/> INITIAL <input type="checkbox"/> RECERT <input type="checkbox"/> MODIFICATION <input type="checkbox"/> EXT OF BENEFITS				START DATE:	
PROVIDER NAME:			PROVIDER MAILING ADDRESS:		
PROVIDER IDENTIFICATION#/TAXONOMY CODE:			PROVIDER PHONE & CONTACT PERSON:		
BENEFICIARY NAME: (LAST, FIRST, MI)				BENEFICIARY MEDICAID ID #:	
BENEFICIARY MAILING ADDRESS:				DATE of BIRTH:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PRESCRIBING PHYSICIAN:			PHYSICIAN IDENTIFICATION #/TAXONOMY CODE:		
PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS REQUESTED	UNITS REQUESTED
<i>I attest that the above information is true to the best of my knowledge.</i>					
_____				_____	
PROVIDER SIGNATURE				DATE	
SECTION B - TO BE COMPLETED BY THE PHYSICIAN					
EST. LENGTH OF NEED: ____ WKS ____ MONTHS ____ PERM		EPSDT REFERRAL: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		CURRENT HEIGHT: INCHES	CURRENT WEIGHT: LBS
DIAGNOSIS & ICD-9 CODE:		DIAGNOSIS & ICD-9 CODE:		DIAGNOSIS & ICD-9 CODE:	
IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO					
MEDICAL NECESSITY FOR REQUESTED SERVICES:					
_____				_____	
PHYSICIAN SIGNATURE				DATE	

A prescription for the requested items **MUST be documented above or a separate prescription **MUST** be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician **WILL** be required. Please retain a copy of this form in your files.

Send completed form to:
Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters
PO Box 180001
Fort Smith, AR 72918

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

- REVIEW TYPE: Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
- DATE(S) OF SERVICE REQUESTED: Enter the requested date(s) of service.
- PROVIDER INFORMATION: Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
- PATIENT INFORMATION: Enter the beneficiary's full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
- PHYSICIAN INFORMATION: Enter the prescribing physician's name, provider identification number, and taxonomy code.
- PROCEDURE CODES: List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
- PERSON SUBMITTING REQUEST: The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

- EST. LENGTH OF NEED: Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician expects that the patient will require the item for the duration of his/her life.
- EPSDT REFERRAL: If applicable, indicate if the request is being made as the result of an EPSDT referral.
- HEIGHT & WEIGHT: Enter the beneficiary's current height measured in inches and weight measured in pounds.
- DIAGNOSIS & ICD-9 CODES: In the first space, list the diagnosis & ICD9 code that represents the primary reason for ordering this item. List any additional diagnosis & ICD9 codes that would further describe the medical need for the item (up to 3 codes).
- QUESTION SECTION: Answer the question by checking the appropriate "YES" or "NO" box.
- MEDICAL NECESSITY: The physician must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are not acceptable.
- **PRESCRIPTION: A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
- **LETTER OF MEDICAL NECESSITY: If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required.