NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

272AFFS i
11/2021

REQUEST FOR SERVICE AUTHORIZATION

FOR ABA SERVICES

(Fee-for-Service (FFS) Program Only - Not for Managed Care program use)
Instructions for filling out this form are attached.

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****
Must use a separate request form for each discipline

RECIPIENT INFORMATION **TODAY'S DATE:**

RECIPIENT NAME: _____DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS (**NOT CODES)**: _____

ALTERNATE INSURANCE: NAME OF PLAN:

PROVIDER INFORMATION

CONTACT PERSON:_____ EMAIL: _____

TELEPHONE #: _____ FAX #:_____

PERFORMING THERAPIST: _____ THERAPIST MEDICAID ID #: _____

REQUESTING FACILITY:_____ REQUESTING FACILITY MEDICAID ID#:_____

TYPE OF TREATMENT	PROCEDURE CODE	FREQUENCY OF TREATMENT	TOTAL # OF VISITS AND UNITS NEEDED	DATES OF SERVICE	
				START	END

ANTICIPATED RESULT(S) OF PROVIDING THESE EXTRA SERVICES: (use additional paper as necessary)

*****CLINICAL INFORMATION** (must be included with submission):***
Pursuant to He-W 568.06: Please attach physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Therapy Care Plan, and progress notes, Face to Face PCP visit note within one year. Specify goals and objectives.

LETTER OF MEDICAL NECESSITY
Pursuant to He-W 530.07(g) attach supporting clinical documentation that addresses how the requested additional services meet the definition of medical necessity.

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

Signature of DME Provider ***Date***

Printed Name ***Title***

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

INSTRUCTIONS FOR ABA SERVICES

Please do **NOT** send instructions in with your request.

This form must be filled out to request services for ABA services to FFS members.

Please note that before this form is filled out, it is **your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at1-866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections of the form are the Recipient Information and Provider Information and should be filled out accordingly. Note that the Performing Therapist is the therapist providing the service and the Requesting Facility is the place where the service is provided. These two provider numbers must be different.

The next section is the service you are requesting. Fill in a description the treatment, the Procedure Code, how often therapy will take place, the total number of units the start and end date of these units.

For your convenience, the section following is the legal information with references to the Medicaid rule. The signature should be that of the therapist performing the services.

To submit documents request a secured email link, by emailing ServiceAuthorizationFFS@dhhs.nh.gov. In the subject line write Requesting Approval for: then choose DME, Incontinence, Therapy etc. You will receive a secured email thread. Alternatively you can use your own process for securing Protected Health Information in documents sent by email. Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Return all documentation and the Service Authorization Request form to SerivceAuthorizationFFS@dhhs.nh.gov or fax to: 603-271-8194.

If the information sent is incomplete, you will receive a request for more information. This is not a denial. Send in the information as above for the request to be reconsidered.

If all information is complete and criteria is met, you will receive a form from the state with the approval information. Once the Request for Service Authorization has been approved by the State it is sent to the Fiscal Agent, Conduent, to create the authorization. Conduent has three business days to create and mail the authorization to the performing provider. If you have questions, please call Conduent at 1-866-291-1674.