NEW HAMPSHIRE MEDICAID

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

Dates of Service: _____

EPSDT: _____SA #: _____

272INC FFS i
09/2021

REQUEST FOR SERVICE AUTHORIZATION
FOR INCONTINENCE PRODUCTS
(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 required)*****

RECIPIENT INFORMATION **TODAY'S DATE:**

RECIPIENT NAME: _____ DATE OF BIRTH:_____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS (NOT CODES): _____
ALTERNATE INSURANCE:

PROVIDER INFORMATION

CONTACT PERSON: EMAIL:

TELEPHONE #: FAX #:

PERFORMING PROVIDER NAME: MEDICAID PROVIDER ID #:

ORDERING PHYSICIAN: ORDERING PHYSICIAN PHONE #:

INCONTINENCE PRODUCT(S) REQUESTED

Description of Product	Procedure Code and Modifier	Units/ mo.	Dates of Service		**STATE USE ONLY**
			Start Date of Service	End Date of Service	

INCONTINENCE PRODUCT(S) CHANGE REQUEST
USE ONLY FOR REVISIONS TO CURRENT SERVICE AUTHORIZATIONS

Service Auth #: Reason for Change:

Description of Product	Procedure Code and Modifier	Units/ mo.	**Dates of Service**			**STATE USE ONLY**
			Date of Change	Date Auth Begins	Date Auth Ends	

DOCUMENTATION OF FACE TO FACE ENCOUNTER: Pursuant to He-W 571.05(h) A Provider shall conduct and document a face-to-face encounter with the recipient no earlier than 60 days prior to submitting a prior authorization request and the Provider's written order shall include the date of the encounter and the primary clinical reason the recipient needs the item(s).
PHYSICIAN'S ORDER: Pursuant to He-W 571.05 (a)(c)(d) a prescription shall be written by the NH licensed Provider including name, date of birth, address, Medicaid number and details of use of equipment.
LETTER OF MEDICAL NECESSITY: Pursuant to He-W 571.05(b)(c)(d) a signed letter of medical necessity shall be written by the NH licensed Provider for the requested DME, including name, date of birth, Medicaid number, a written diagnosis, anticipated length of use and supporting clinical documentation.

For the items listed above: (*PLEASE CHECK BOXES TO THE LEFT AND INCLUDE ALL IN FAX.)**

- ☐ I certify that I have obtained and attached a Face-to-Face documentation pursuant to He-W 571.05(h).
- ☐ I certify that I have attached a Physician's order and a LMN pursuant to He-W 571.05(d).
- ☐ I certify that products listed will be provided to the recipient.

Signature of Incontinence Product Provider Date Printed Name Title

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

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 271-8194

INSTRUCTIONS FOR INCONTINENCE PRODUCTS: FORM 272DIA FFS REQUEST FOR INCONTINENCE PRODUCTS

This form must be filled out pursuant to He-W 571.05 Prescription, LMN, and Prior Authorization Requests.

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 at 1-866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

We have combined two forms into this one form. This form will be used both for the ordering of incontinence products and for revisions (changes in size, quantity etc.) of current service authorizations.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Note if there is an Alternate Insurance, NH Medicaid is the payer of last resort. We will need an Explanation of Benefit from the first insurance company or a denial letter in order to process your request.

The next section is the service you are requesting. For new orders, fill in a description of the incontinence product, the Procedure Code and modifier, the number of units, and the start and end date of service. Please note all requests for in excess of allowable units should use the U1 modifier. If you need to change an existing SA, use next section, Change Request. Write in the current SA number and reason for the change. Then fill in a description of the incontinence product, the Procedure Code and modifier, the number of units, and the start of the change and end date of service for that current service authorization.

For your convenience, the section following is the legal information with references to the Medicaid rule, for your convenience. Note that you are **now required to attest, by signature,** that you have the Face to Face documentation in your possession. The signature should be that of the provider 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.