NEW HAMPSHIRE MEDICAID

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

Dates of Service: _____

EPSDT: _____SA #: _____

273S FFS
09/2021

REQUEST FOR SERVICE AUTHORIZATION
FOR SURGICAL PROCEDURES, INCLUDING ORGAN TRANSPLANTS
Fee-for-Service (FFS) Program Only –
Not for Managed Care program use
PLEASE PRINT OR TYPE ALL INFORMATION (All fields are required)
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

DATE(S) OF SERVICE: _____ CONTACT PERSON:_____

TELEPHONE #: _____ EMAIL: _____

FAX #: _____

PERFORMING PROVIDER NAME: _____ MEDICAID PROVIDER ID #: _____

ORDERING PHYSICIAN: ORDERING PHYSICIAN PHONE #:

SURGIAL PROCEDURE OR TYPE OF ORGAN TRANSPLANT FOR WHICH SERVICE AUTHORIZATION IS BEING REQUESTED

Procedure	Procedure Code and Modifier	CORRESPONDING ICD-CM CODE	Anticipated Dates of Service	
			Begin Date of Service	End Date of Service

Pursuant to He-W 531.07(d) Prior authorization requested in accordance with 531.07(a) through (c) shall be approved by the department's prior authorization agent if the department's prior authorization agent determines that the submitted documentation supports the applicable requirements in He-W 531.05.

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

☐ To the best of my knowledge, the above information is true and accurate and supports medically necessary criteria as specified in the Physician Services rule (He-W 531) for the surgical procedure/organ transplant identified above.

Signature of Performing Provider Date Printed Name Title

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

INSTRUCTIONS FOR SURGICAL PROCEDURES AND TRANSPLANTS: FORM 273S FFS REQUEST FOR SERVICE AUTHORIZATION FOR SURGICAL PROCEDURES, INCLUDING ORGAN TRANSPLANTS

This form must be filled out pursuant to He-W 531.07(d)Prior authorization requested in accordance with 531.07(a) through (c) shall be approved by the department's prior authorization agent if the department's prior authorization agent determines that the submitted documentation supports the applicable requirements in He-W 531.05.

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

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Note that the performing surgeon and performing facility will have different Medicaid ID numbers.

The next section is what you are requesting. Fill in a description of the procedure, the Procedure Code and the corresponding ICD-CM Code.

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

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.

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