NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____
Dates of Service: _____
EPSDT: _____SA #: _____

272EPOS FFS
09/2021

REQUEST FOR SERVICE AUTHORIZATION

IN EXCESS OF SERVICE LIMITS FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY

(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 NUMBER OF VISITS	DATES OF SERVICE		STATE USE ONLY
				START DATE OF SERVICE	END DATE OF SERVICE	

FOR STATE USE ONLY

*****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. 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 Therapist Performing Services 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 PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY: FORM 272EPOS FFS REQUEST FOR SERVICE AUTHORIZATION IN EXCESS OF SERVICE LIMITS FOR PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY

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

This form must be filled out to request services in excess of 20 visits per recipient, per therapy type, per state fiscal year (7/1 through 6/30.) as noted in the Provider notice from January 7, 2019, "**Change in PT/OT/ST Service Limits Effective January 1, 2019.**"

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. **Each discipline must have its own SA, FORM 272EPOS**. Fill in a description the treatment, the Procedure Code, how often therapy will take place, the total number of visits requested and the start and end date of these extra 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.