



NEW HAMPSHIRE MEDICAID

For State use only.	<b>APPROVED</b>
Date: _____	By: _____
Dates of Service: _____	
EPSDT: _____ SA #: _____	

272D FFS  
09/2021  
Page 1 of 2

**REQUEST FOR SERVICE AUTHORIZATION  
FOR DURABLE MEDICAL EQUIPMENT (DME)**

(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)\*\*\***

<b>RECIPIENT INFORMATION</b>	<b>TODAY'S DATE:</b>
RECIPIENT NAME: _____	DATE OF BIRTH: _____
RECIPIENT MEDICAID ID #: _____	DIAGNOSIS CODES: _____
ALTERNATE INSURANCE: NAME OF PLAN _____	

<b>PROVIDER INFORMATION</b>	
CONTACT PERSON: _____	EMAIL: _____
TELEPHONE: _____	FAX #: _____
PROVIDER NAME #: _____	PROVIDER MEDICAID ID #: _____

**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 Service 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 below requested DME, including name, date of birth, Medicaid number, a written diagnosis, anticipated length of use and supporting clinical documentation.

**MOBILITY EVALUATION FORM AND NON-WHEELCHAIR EVALUATION FORM:** Pursuant to He-W 571.05(c), requests for all wheelchairs, scooters, and customized strollers must also include a completed Form 272M, "Mobility Evaluation Form" Pursuant to He-W 571.05(e), requests for all standers, gait trainers, and bath and toileting items shall also include a completed Form 272EQ, "Medical Equipment Request Evaluation Form Non-Wheelchair"

**For the items listed below: (\*\*\*)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 items listed will be provided and that the documentation regarding our acquisition costs reflects best price (Usual and customary pursuant to Section 126-A:3).
- The Mobility Evaluation form or the Medical Equipment Request Form is signed by all parties and attached.
- I have attached the manufacturer's quote with the MSRP and acquisitions costs clearly defined.

_____	_____
<i>Signature of DME Provider</i>	<i>Date</i>
_____	_____
<i>Printed Name</i>	<i>Title</i>
<i>Approval is a determination that the services requested are medically necessary and not a guarantee of payment.</i>	

**PLEASE LIST ALL DME PRODUCTS BEING REQUESTED ON PAGE 2**





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**INSTRUCTIONS FOR DURABLE MEDICAL EQUIPMENT:**

**FORM 272D FFS REQUEST FOR DURABLE MEDICAL EQUIPMENT**

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

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 if there is an Alternate Insurance, NH Medicaid is the payer of last resort. We will need an Explanation of Benefit from the primary insurance company or a denial letter in order to process your request.

For your convenience, the section following is the legal information with references to the Medicaid rule. 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. **\*\*Also note that we cannot process any wheelchairs, scooters, customized strollers, standers, gait trainers, and bath and toileting items without the 272M FFS Mobility Evaluation Form Wheelchair or 272EQ FFS Non-Wheelchair Evaluation Form attached pursuant to He-W 571.05(c) and He-W 571.05(e).**

The next section, page 2, is the equipment you are requesting. Fill in a description of the DMEs, the Procedure Code and an RR modifier if it is a rental, the number of units, the acquisition cost **per unit**, the manufacturer's suggested retail (on your vendor's quote form) **per unit (we cannot process without the cost information)**, the monthly rental charge **per unit**, and the start and end date of service. **\*\*Note that proof of your costs must be attached.**

To submit documents request a secured email link, by emailing [ServiceAuthorizationFFS@dhhs.nh.gov](mailto: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 [ServiceAuthorizationFFS@dhhs.nh.gov](mailto:ServiceAuthorizationFFS@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.