

**INSTRUCTIONS**  
**DHS 1144E (Rev. 09/03)**  
**REQUEST FOR MEDICAL AUTHORIZATION OF EPSDT MEDICALLY FRAGILE**  
**CASE MANAGEMENT, SKILLED NURSING AND PERSONAL CARE SERVICES**

**I. Purpose:** The DHS 1144E Form is used to obtain medical authorization of case management, hourly skilled nursing and personal care services for Medicaid recipients under age 21 years who are medically fragile. EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment. EPSDT is the Medicaid program for Medicaid recipients under age 21 years.

**II. General Instructions:** Type or print legibly. *An incomplete form will be returned to the provider.*

**A. Recipient Information:** *This section is to be completed by the provider.*

1. Enter Medicaid ID number, Patient's Name, Date of Birth (mm/dd/yy), and Gender.
2. Check type of Present Address, and provide Patient's Mailing Address.
3. If the recipient has other health care insurer(s) for medical care, check "yes" and name the insurer.

**B. Physician Information:** *This section is to be completed by the physician.* The form will be returned if numbers 1-7 are not checked and/or if the physician's signature and physician's printed name are not provided.

1. Check "Yes" or "No" for Ventilator Dependent and Tracheostomy. If Ventilator dependent, state the number of hours per day the recipient uses the ventilator. If tracheostomy without ventilator, state the number of times per day suctioning is required. If "Other" is checked, list the specific diagnosis(es) and the reason the recipient qualifies as being medically fragile. If insufficient space, attach a separate page.
2. Check "Yes" or "No" for the services requested and the number of hours per day requested for hourly skilled nursing and personal care. Attach a completed/signed/dated EPSDT Home Skilled Nursing Scoring Tool if skilled nursing services are requested.
3. Check "Yes" or "No" in the appropriate box to indicate for medically fragile case management. Attach a completed/signed/dated EPSDT Medically Fragile Case Management Scoring Tool.

The services requested on a single form must be provided by a single agency. Therefore, if skilled nursing and personal care are provided by the same agency, they may be requested on the same form. However, if case management is provided by another agency, a separate form must be completed.

4. The physician who is requesting services must verify that recipient is under his/her care and that the requested services are medically necessary and are NOT for respite. The physician must sign and date the form.
5. Print legibly or stamp Physician/Provider Name and Provider Number.
6. Provide Contact Name (if different from physician), Telephone Number, and Fax Number where the Medicaid Consultant can contact Provider if additional information is needed to process the request.

**C. Supplier Information:**

This section is to be completed by the EPSDT Medically Fragile Case Management Supplier.

1. Circle the appropriate code(s) and complete the quantity per month. The quantity should be one (1) except for T1017-EP. Enter the period requested.

This section is to be completed by the Skilled Nursing/Personal Care Supplier/Agency.

1. Circle applicable code(s) and enter the quantity in hours requested per month and the period requested.

*Both Medically Fragile Case Management Supplier and Skilled Nursing/Personal Care Supplier/Agency.*

1. Certify 1 and 2 by signing and dating. If the recipient has primary insurer other than Medicaid, please verify with the insurer whether the services requested will be covered.
2. Print legibly or stamp Supplier Name and Supplier Number. The supplier name and supplier Medicaid I.D. number should match the name and number registered with the Med-QUEST Division.
3. Provide Contact Name (if different from supplier), Telephone Number, and Fax Number where the Medicaid Consultant can contact Supplier if additional information is needed to process the request.

**D. Medicaid Only:** *This section is to be completed by the Medicaid Consultant.*

1. Consultant will indicate the Quantity/Month approved.
2. Consultant will assign a Code for each item; such as: A – Approved, P – Pend, D – Denied, or R – Revoked.
3. Consultant will enter Period Approved.
4. Consultant will write comment(s), as needed.

**E.** Upon receipt of this 1144E Form, ACS will assign a prior authorization number.