Clear Form

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS
P.O. Box 2561
Honolulu, Hawaii 96804-2561

REQUEST FOR MEDICAL AUTHORIZATION OF EPSDT MEDICALLY FRAGILE CASE MANAGEMENT, SKILLED NURSING AND PERSONAL CARE SERVICES

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant. Do not submit for patients in SNF/ICF/ICF-MR facility as payment is included in the facility's per diem.

PLEASE PRINT INFORMATION CLEARLY

Medicaid I.D. No.:	**Patient's Name: (Last, First, M.I.)**	**Date of Birth:**	**Gender:** ☐ F ☐ M	**Has Other Insurance:** ☐ Yes _____ ☐ No (If yes, name of insurance co.)
Present Address (Street, City and Zip Code):				☐ Own Home/Family Home ☐ Other_____

TO BE COMPLETED BY PHYSICIAN. FAILURE TO COMPLETE NUMBERS 1 – 7 WILL RESULT IN RETURN OF REQUEST.

	Yes	No		List specific diagnosis(es):
1) Ventilator dependent			If yes, indicate # of hours/day:	
2) Tracheostomy; no ventilator			If yes, indicate frequency of suctioning:	
3) Other				

	Yes	No			Yes	No
4) Requested service is Skilled Nursing			If yes, indicate # of hours/day:	6) Requested service is Case Management		
5) Requested service is Personal Care			If yes, indicate # of hours/day:	7) Required justification is attached		

I certify that the above named patient is under my care and the service(s) requested are medically necessary and are NOT for respite (i.e., relieving caregiver(s) for rest or other activities).

Physician's Signature: _____ ***Date:*** _____

Print Physician's/Provider's Name:		Provider Number:
Contact Name: (If different from Physician)	Telephone Number:	Fax Number:

To be completed by Case Management Supplier — **Medicaid Only A=Approved P=Pended D=Denied R=Revoked**

Code	Item	Qty./Mo.	Period Requested	Qty./Mo.	Auth.	Period Approved	Comments
T1016-22	Case Management for Tracheostomized and/or Ventilator dependent child (following initial discharge to home/community).		From: To:			From: To:	
T1016-EP	Case Management for Tracheostomized and/or Ventilator dependent child living in home/community.		From: To:			From: To:	
T1016	Case Management for Non-Ventilator/Non-Tracheostomized child with significant medical needs.		From: To:			From: To:	
T1016-52	Maintenance Case Management for child with significant medical needs whose caregiver(s) are able to access services and supplies with little assistance from case managers.		From: To:			From: To:	
T1017-EP	Additional Case Management hours provided with T1060 and T1060-52 to address changing medical needs.		From: To:			From: To:	

To be completed by Skilled Nursing/Personal Care Supplier/Agency

T1030*	Skilled Nursing services in the home; by hourly basis.		From: To:			From: To:	
T1021	Personal Care Services in the home; by hourly basis.		From: To:			From: To:	

*** When submitting a claim, indicate the service hours provided by the RN with the code T1030; indicate the service hours provided by the LPN with the code T1030-52.**

1) I certify that the services requested above have been prescribed by the physician named above and will be provided by me/my agency.

2) I also certify that I have verified that if the above named patient has a primary insurer other than Medicaid (name)_____, the primary insurer ☐ ***will not cover the services above*** ☐ ***will cover the services above.***

Signature of Supplier/Agency: _____ ***Date:*** _____

Print Supplier's Name/Mailing Address:		**Supplier Number:**
Contact Name:	**Telephone Number:**	**Fax Number:**

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