Washington State
Health Care Authority

General Information for Authorization

Org	1.		Service Type	2.
Client Information				
Name	3.		Client ID	4.
Living Arrangements	5.		Reference Auth #	6.
Provider Information				
Requesting NPI #	7.		Requesting Fax #	8.
Billing NPI #	9.		Name	10.
Referring NPI #	11.		Referring Fax #	12.
Service Start Date:	13.			14.
Service Request Information				
Description of service being requested: 15.			16.	17.
18. Serial/NEA or MEA #			19.	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #

Medical Information				
Diagnosis Code	27.	Diagnosis name	28.	
Place of Service Code	29.			
30. Comments:				

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org **(Required)**	Enter the Number that Matches the Program/Unit for the Request 501 – Dental 502 – Durable Medical Equipment (DME) 504 – Home Health 505 – Hospice 506 – Inpatient Hospital 508 – Medical 509 – Medical Nutrition 511 – Outpt Proc/Diag 513 – Physical Medicine & Rehabilitation (PM & R) 514 – Aging and Long-Term Support Administration (ALTSA) 518 – LTAC 519 – Respiratory 521 – Maternity Support/Infant Case Management 524 – Concurrent Care 525 – ABA Services 526 – Complex Rehabilitation Technology (CRT) 527 – Chemical-Using Pregnant (CUP) Women Program
2	Service Type **(Required)**	Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – **Dental**" for field #1, please select one of the following codes for this field: ASC — for ASC IP — for In-Patient CWN — for Crowns ODC — for Orthodontic DEN — for Dentures OUTP — for Out-Patient DP — for Denture/Partial PSM — for Perio-Scaling/Maintenance ERSO — for ERSO-PA PTL — for Partial EXT — for Extractions RBS — for Rebases EXTD — for Extractions w/Dentures RLNS — for Relines GA — for General Anesthesia TC — for Transfer Case GAE — for General Anesthesia w/ extractions MISC — for Miscellaneous If you selected "502 – **Durable Medical Equipment (DME)**" for field #1, please select one of the following codes for this field: AA — for Ambulatory Aids OS — for Orthopedic Shoes BB — for Bath Bench OTC — for Orthotics BEM — for Bath Equipment (misc.) OP — for Ostomy Products BGS — for Bone Growth Stimulator ODME — for Other DME BP — for Breast Pump OTRR — for Other Repairs C — for Commode PL — for Patient Lifts CG — for Compression Garments PWH — for Power Wheelchair - Home CSC — for Commode/Shower Chair PWNF — for Power Wheelchair – NF DTS — for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing) PWR — for Power Wheelchair Repair PRS — for Prone Standers PROS — for Prosthetics ERSO — for ERSO-PA RE — for Room Equipment FSFS — for Floor Sitter/Feeder Seat SC — for Shower Chairs HB — for Hospital Beds SBS — for Specialty "Beds/Surfaces HC — for Hospital Cribs SGD — for Speech Generating Devices IS — for Incontinent Supplies SF — for Standing Frames MWH — for Manual Wheelchair - Home STND — for Standers TU — for TENS Units MWNF — for Manual Wheelchair – NF US — for Urinary Supplies MWR — for Manual Wheelchair Repair WDCS — for VAC/Wound - decubiti supplies MISC — for Miscellaneous

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2	Service Type **(Required)** (Continued)	If you selected "504 – **Home Health**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA MISC for Miscellaneous HH for Home Health T for Therapies (PT / OT / ST)
		If you selected "505 – **Hospice**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA HSPC for Hospice MISC for Miscellaneous
		If you selected "506 – **Inpatient Hospital**" for field #1, please select one of the following codes for this field: BS for Bariatric Surgery RM for Readmission ERSO for ERSO-PA S for Surgery OOS for Out of State TNP for Transplants O for Other VNSS for Vagus Nerve Stimulator PAS for PAS MISC for Miscellaneous
		If you selected "508 – **Medical**" for field #1, please select one of the following codes for this field: BSS2 for Bariatric Surgery Stage 2 NP for Neuro-Psych BTX for Botox OOS for Out of State CIERP for Cochlear Implant PSY for Psychotherapy Exterior Replacement Parts SYN for Synagis CR for Cardiac Rehab T for Therapies (PT/OT/ST) ERSO for ERSO-PA TX for Transportation HEA for Hearing Aids V for Vision I for Infusion / Parental VST for Vest Therapy VT for Vision Therapy MC for Medications MISC for Miscellaneous
		If you selected "509 – **Medical Nutrition**" for field #1, please select one of the following codes for this field: EN for Enteral Nutrition MN for Medical Nutrition MISC for Miscellaneous
		If you selected "511 – **Output Proc/Diag**" for field #1, please select one of the following codes for this field: CCTA for Coronary CT Angiogram OOS for Out of State CI for Cochlear Implants OTRS for Other Surgery ERSO for ERSO-PA PSCN for PET Scan GCK for Gamma/Cyber Knife O for Other GT for Genetic Testing S for Surgery HO for Hyperbaric Oxygen SCAN for Radiology HY for Hysterectomy MISC for Miscellaneous MRI for MRI
		If you selected "513 – **Physical Medicine & Rehabilitation (PM & R)**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA PMR for PM and R MISC for Miscellaneous

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2	Service Type **(Required)** (Continued)	If you selected "514 – **Aging and Long-Term Support Administration (ALTSA)** for field #1, please select one of the following codes for this field: PDN for Private Duty Nursing MISC for Miscellaneous
		If you selected "518 – **LTAC**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA LTAC for LTAC O for Other
		If you selected "519 – **Respiratory**" for field #1, please select one of the following codes for this field: CPAP for CPAP/BiPAP OXY for Oxygen ERSO for ERSO-PA SUP for Supplies NEB for Nebulizer VENT for Vent OXM for Oximeter O for Other
		If you selected "521 – **Maternity Support/Infant Case Management (MSS)"** for field #1, please select one of the following codes for this field: ICM for Infant Case Management PO for Post Pregnancy Only PPP for Prenatal/Post Pregnancy O for Other
		If you selected "524 – **Concurrent Care**" (for children on Hospice) for field #1, please select one of the following codes for this field: CC for Concurrent Care Services
		Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "525 – **ABA Services**" for field #1, please select one of the following codes for this field: IH for In Home/Community/Office DAYP for Day Program
		If you selected "526 – **Complex Rehabilitation Technology**" (CRT) for field #1, please select one of the following codes for this field: ERSO for ERSO-PA PWH for Power Wheelchair - Home MWH for Manual Wheelchair - Home PWNF for Power Wheelchair – NF MWNF for Manual Wheelchair - NF PWR for Power Wheelchair Repairs MWR for Manual Wheelchair Repairs PWS for Power Wheelchair Supplies MWS for Manual Wheelchair Supplies
		If you selected "527 – **Chemical-Using Pregnant (CUP) Women Program**" for field #1, please select one of the following codes for this field: DX for Detox DM for Detox/Medical Stabilization MS for Medical Stabilization

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3	Name: **(Required)**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: **(Required)**	Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ▪ You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit. ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: **(Required)**	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: **(Required)**	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: **(Required).**	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: **(Required).**	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD - 9/10 Diagnosis Code R - Rev Code N - NDC - National Drug Code S – ICD - 9/10 Proc Code
21	National Code: **(Required).**	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: **(Units or $ required).**	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Medicaid Provider Guide for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: **(Units or $ required).**	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Medicaid Provider Guide and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00).
25	Part # (DME only): (**Required for all requested codes).**	Enter the manufacturer part # of the item requested.

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26	Tooth or Quad#: **(Required for dental requests).**	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82	
27	Diagnosis Code	Enter appropriate diagnosis code for condition.	
28	Diagnosis name	Short description of the diagnosis.	
29	Place of Service	Enter the appropriate two digit place of service code.	
		Place of Service Code(s)	**Place of Service Name**
		1	Pharmacy
		3	School
		4	Homeless Shelter
		5	Indian Health Service Free-standing Facility
		6	Indian Health Service Provider-based Facility
		7	Tribal 638 Free-standing Facility
		8	Tribal 638 Provider-based Facility
		9	Prison-Correctional Facility
		11	Office
		12	Home
		13	Assisted Living Facility
		14	Group Home
		15	Mobile Unit
		16	Temporary Lodging
		17	Walk in Retail Health Clinic
		20	Urgent Care Facility
		21	Inpatient Hospital
		22	Outpatient Hospital
		23	Emergency Room – Hospital
		24	Ambulatory Surgical Center
		25	Birthing Center
		26	Military Treatment Facility
		31	Skilled Nursing Facility
		32	Nursing Facility
		33	Custodial Care Facility
		34	Hospice
		41	Ambulance - Land
		42	Ambulance – Air or Water
		49	Independent Clinic
		50	Federally Qualified Health Center
		51	Inpatient Psychiatric Facility

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FIELD	NAME	ACTION		
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29	Place of Service	52	Psychiatric Facility-Partial Hospitalization	
		53	Community Mental Health Center	
		55	Residential Substance Abuse Treatment Facility	
		56	Psychiatric Residential Treatment Center	
		57	Non-residential Substance Abuse Treatment Facility	
		60	Mass Immunization Center	
		61	Comprehensive Inpatient Rehabilitation Facility	
		62	Comprehensive Outpatient Rehabilitation Facility	
		65	End-Stage Renal Disease Treatment Facility	
		71	Public Health Clinic	
		72	Rural Health Clinic	
		81	Independent Laboratory	
		99	Other Place of Service	
30	Comments	Enter any free form information you deem necessary.		