NC DHB Request for Prior Approval CMN/PA

Recipient Information **DMA372-131 V1.0**

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting Provider #:_____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____

9. Address: _____ 10. Nine Digit Zip Code: _____

11. Billing Provider # (if different from requesting):_____NPI: ☐ Atypical: ☐ 12. Taxonomy: _____

13. Address: _____ 14. Nine Digit Zip Code: _____

15. Rendering Provider # (if different from billing):_____NPI: ☐ Atypical: ☐ 16. Taxonomy: _____

17. Address: _____ 18. Nine Digit Zip Code: _____

Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Medical and Functional Status

19. **Condition:** Stable: ☐ Unstable: ☐ Height: _____ Weight: _____

20. **Prognosis:** Terminal: ☐ Poor: ☐ Guarded: ☐ Fair: ☐ Good: ☐ Excellent: ☐

21. **Patient:** Requires positioning not feasible in ordinary bed: ☐ Unattended for long periods of time: ☐ Lives alone: ☐

22. **Equipment:** Necessary to retard deterioration of condition: ☐ Necessary for function: ☐ Specify_____ Length of need: _____

23. **Mental:** Oriented: ☐ Forgetful: ☐ Disoriented: ☐ Agitated: ☐ Comatose: ☐ Depressed:☐ Lethargic: ☐ Infant: ☐ Other: _____

24. **Neurological:** Muscle Tone: Normal: ☐ Increased: ☐ Decreased: ☐ Fluctuating: ☐

Sensation: Normal: ☐ Abnormal: ☐ Specify:_____

25. **Respiratory:** Normal: ☐ SOB on minimal exertion: ☐ Tracheostomy: ☐

O2: ☐ Flow Rate:_____ Frequency: _____ Test Date: _____ Results: _____

26. **Skin:** Normal: ☐ Other: ☐ Specify: _____ Decubiti: ☐ Specify: _____

27. **Ambulatory:** Complete bedrest: ☐ Up as tolerated: ☐

Transfers bed-chair (indep): ☐ Transfers bed-chair (w/assistance): ☐ Confined to wheelchair?☐ Hours per day: _____

Walks unassisted: ☐ Walks with assistive device: ☐ Specify: _____ Max distance walked: _____

28. Can place of residence physically accommodate equipment being requested? ☐ Yes ☐ No

29. Patient's status will be monitored by physician while assistance is provided? ☐ Yes ☐ No

30. Medical Necessity of equipment: _____

_____

_____

Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

_____ _____ _____ _____ _____ _____

Requesting Provider's Signature Date Physician, PA, Nurse Practitioner Signature Date

Fax this form to: (855) 710-1964