



PCA Prior Authorization Adjustment Form

☒ Increase
☐ Decrease

PCA Consumer Name

MassHealth ID#

PCM Agency

Prior Authorization #

Current Authorization						Requested Authorization				Comments
Specify activity ADL/IADL	PCA time in minutes	Frequency		Total minutes per week currently authorized	PCA time in minutes	Frequency		Adjustment minutes per week requested		
		Times per day	Days per week			Times per day	Days per week			
						Total requested adjusted weekly day/evening PCA hours				
Number of hours currently authorized per night	Specify activity ADL/IADL	PCA time in minutes	Frequency		Total billable hours per night	PCA time in minutes	Frequency		Billable hours per night requested	Comments
			Times per night	Nights per week			Times per night	Nights per week		
						Total requested adjusted billable hours per night				

Is Consumer receiving or about to receive any home-based services? ☒ Yes ☐ No

If "yes", list additional services:



PCA Prior Authorization Adjustment Form (cont.)

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Section 1: Additional Comments (to be filled out by the PCM agency)

Please provide additional comments to support the adjustment request (attach additional sheets and supporting documentation as necessary)

On this date I reviewed this adjustment request with the consumer: ☐ In Person ☒ Telephonically

Signature of PCM Agency Reviewer

Title

Date

Section 2: Hours Requested (to be filled out by the PCM agency)

Current day/evening hours per week

Requested total day/evening hours per week

Current night hours per week

Requested total night hours per week

Adjustment request is from date

through date

Section 3: Administrative Adjustment (to be filled out by the PCM agency) OPTIONAL— skip section if this does not apply

☐

This adjustment request is due to an administrative correction and does **not** require a PCP Signature (i.e. the removal/addition of time for a task that is duplicative with another service provider Prior Authorization, an RN/LPN/OT omission, etc.)

Please provide additional comments to support the adjustment request:



PCA Prior Authorization Adjustment Form (cont.)

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Section 4: PCP/Clinical Documentation

In addition to this adjustment form signed by the PCM Clinical Evaluator, **ONE** of the following has been included with this Adjustment request:

- ☐ PCP signature on the Adjustment Form (please complete below)
- ☐ A letter from the Consumer's PCP supporting the need for an adjustment
- ☐ A completed PCP Summary Form (required if asking for an adjustment for complex care tasks)
- ☐ The Consumer's Electronic Medical Record (EMR) that supports the need for an adjustment
- ☐ N/A this is an Administrative Adjustment request

PCP Comments:

I have reviewed and agree with this request for an adjustment in this Consumer's authorized number of hours of PCA Services. The adjustment is a result of changes in the Consumer's condition and/or functional status or a change in living condition that affects the Consumer's ability to perform ADLs/IADLs without physical assistance.

Signature of PCP

Date

Print Name of PCP

Phone

Address of PCP