MassHealth

Commonwealth of Massachusetts • EOHHS

[www.mass.gov/masshealth](http://www.mass.gov/masshealth)

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Providers must complete items 1-22 or risk delays, as described at 130 CMR 450.303(B).

1. Provider’s Name, Address, and Tel.
Contact Name
Contact Tel. No.
Contact Email
Contact FAX

2. Provider ID/Service Location or NPI

3. PA Assignment

4. Member’s Name, Address, and Tel. No.

5. Place of Residence: Home Nursing facility Rehab. Hospital Other:

6. Height \_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_ in.

7. Weight \_\_\_\_\_\_\_ lb. \_\_\_\_\_\_\_ oz.

8. Gender M F

9. Other Insurance Yes No

10. Full Name of Insurance Carrie

11. Date of Birth

12. Member ID

13. Community Case Management Member Identifier Yes No

14. Explain why this service is medically necessary. Include the diagnosis, place of service, and a description of the proposed treatment. Attach supporting documentation if required by MassHealth regulations.

Primary Diagnosis

Secondary Diagnosis

Diagnosis Code(s)

Place of Service

Description of Treatment

## SERVICES REQUESTED

15. Servicing Provider ID/Service Location or NPI

16. Service Code (Use a separate line for each code.) Include modifier if code requires one.

17. No. of Units (Enter at least 1.)

18. Attachments Yes No

19. Date PA Requested

20. Requested Effective Date

21. Requested End Date

22. Provider Signature

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider’s signature
The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Printed legal name of provider

Printed legal name of individual signing (if the provider is a legal entity)

# INSTRUCTIONS FOR COMPLETING THE PA-1 FORM (PLEASE PRINT OR TYPE.)

## General Instructions

Complete Items 1–22 only. Enter all dates in mm/dd/yyyy format. Below are instructions for specific fields. All other fields are self-explanatory.

Provider Information Section

Item 1
Provider’s Name, Address, and Tel. No. Enter the provider’s name, address, and phone number (including area code).

Item 2
Provider ID/Loc or NPI Enter the nine-digit requesting-provider ID followed by the one-character location code. If not available, enter the requesting provider’s 10-digit national provider identifier.

Item 3
PA Assignment Select the type of PA you are requesting from this list of basic medical or long-term services and supports (LTSS) services:

Basic Medical

Early Intervention

Hearing Services

Physician-Adult

Physician-Pediatric

Vision

Wigs

Other

LTSS

Home Health/Personal Care Attendant

CarePlus Skilled Nursing

Home Health

Personal Care Attendant (PCA) Services

Durable Medical Equipment

AAC Non- Dedicated Device Absorbent Products

DME–Other

Enterals

Mobility and Repairs

Orthotics and Prosthetics

Oxygen

PERS

Standers

Therapy Services

Occupational Therapy

Physical Therapy

Speech/Language Therapy

Member Information Section

Item 4
Member’s Name, Address, and Tel. No. Enter the member’s name, address, and phone number (including area code).

Item 13
Community Case Management

Select the “Yes” box if the member for which the service is being requested is enrolled in the Community Case Management Program (CCM). CCM provides case management services to complex care members who require a nurse visit of more than two continuous hours of nursing services to remain in the community, as determined by MassHealth or its designee. CCM enrollment can be confirmed by checking the members’ eligibility on the MassHealth Eligibility Verification System (EVS), or by checking the eligibility panel of the Provider Online Service Center (POSC). On the POSC left navigation, select Manage Members, then Verify Member, then Eligibility.

Item 14
Explain why this service is medically necessary

Diagnosis Code(s)

Place of Service

Description of Treatment

Enter a statement explaining why the proposed service is medically necessary. Include the primary diagnosis and secondary diagnosis if there is one. Also include a description of the proposed treatment and prognosis. Refer to your MassHealth provider manual for additional information about this field. Enter the ICD diagnosis code(s) from ICD-10 for the most relevant diagnoses for the procedure or item being requested. Enter the location of service. Enter a narrative of the proposed treatment.

Services Requested Section

Item 15
Servicing Provider ID/Service Location or NPI

Enter the nine-digit servicing-provider ID followed by the one-character service location code. Write “same” if same as requesting provider ID/Service Location. If not available, enter the provider’s 10-digit national provider identifier.

Item 16
Service Code

Enter the appropriate CPT or HCPCS code for each service requested. Refer to Subchapter 6 of the applicable MassHealth provider manual to determine payable service codes. You must include a modifier if the service code requires one.

Item 17
No. of Units

Enter the number of times that the service for which you are requesting PA will be furnished. At least “1” must be entered.

Attachments and Signature

Item 18
Attachments

Select the “Yes” box if additional information or supporting documentation is attached (refer to your provider manual); otherwise select the “No” box. Be certain that the attached documentation clearly supports the medical necessity for the services and/or equipment you are requesting (for example, X-rays, admission notes, photographs, or explicit details).

Item 22
Provider Signature

The form must be signed by the provider or, in the case of a legal entity, an individual duly authorized to act on behalf of the provider to certify that the information entered on the form is correct. The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature

See Subchapter 5 of your MassHealth provider manual for additional instructions for requesting PA.

INSTRUCTIONS FOR MAILING REQUESTS FOR PRIOR AUTHORIZATION (See Item 3 above for Basic Medical or LTSS service options)

For PA requests for basic medical services, mail the Prior Authorization Request form, together with all necessary attachments, to the following address:

MassHealth

ATTN: Prior Authorization
100 Hancock Street, 6th Floor
Quincy, MA 02171

For PA requests for LTSS services, mail the Prior Authorization Request form, together with all necessary attachments, to the following address:

MassHealth LTSS
P.O. Box 159108
Boston, MA 02215