# Prior Authorization Request

Commonwealth of Massachusetts | EOHHS | www.mass.gov/masshealth

This form may only be used by MassHealth Providers with an approved paper claim submission waiver. Use of this form without an approved waiver is strictly prohibited.

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).

☐ Request to Expedite ☐ Standard

| 1. Provider's Name, Address, and Tel. | 4. Member's Name, Address, and Tel. |
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| Contact Name | 5. Place of Residence: ☐ Home ☐ Nursing Facility ☐ Rehab. Hospital ☐ Other: _____ |
| Contact Tel. | 6. Height _____ ft. _____ in. \| 7. Weight _____ lb. _____ oz. \| 8. Gender ☐ M ☐ F |
| Contact Email | 9. Date of Birth / / \| 10. Member ID |
| Contact Fax | 11. Other Insurance ☐ Yes ☐ No |
| 2. Provider ID/Service Location or National Provider Identifier (NPI) | 12. Full Name of Insurance Carrier |
| 3. PA Assignment | 13. Community Case Management (CCM) Member Identifier ☐ Yes ☐ No |

| 14. Reason This Service Is Medically Necessary. Include the diagnosis, the place of service, and a description of the proposed treatment as well as the prognosis. Attach supporting documentation if required by MassHealth regulations. | 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) |
| Primary Diagnosis | A | | | |
| Secondary Diagnosis (if any) | B | | | |
| ICD Diagnosis Code(s) | C | | | |
| Place of Service | D | | | |
| Description of Treatment | E | | | |
| | 18. Attachments ☐ Yes ☐ No | | | |
| | 19. Date PA Requested / / | | 20. Requested Effective Date / / | 21. Requested End Date / / |

Print Clear

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 the provider's behalf. 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 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 Person Signing (if the provider is a legal entity) |
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# 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.

Standard PA: PA requests that comply with all submission/documentation requirements will receive a decision in seven days.

Expedited PA: MassHealth will evaluate all requests to expedite PA. If MassHealth determines that the standard seven-day timeframe may pose a serious risk to the member's life or health, a PA decision will be issued in 72 hours.

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| Item 1 | Provider's Name, Address, and Tel. | Enter the provider's name, address, and phone number (including area code). |
| Item 2 | Provider ID/Loc or National Provider Identifier (NPI) | Enter the requesting provider's 9-digit ID followed by the one-character location code. If that is not available, enter the requesting provider's 10-digit NPI. |
| Item 3 | PA Assignment | Select the type of PA you are requesting from this list of basic medical services or long-term services and supports (LTSS): |

| **Basic Medical** | **LTSS** | | |
|---|---|---|---|
| | **Home Health/Personal Care Attendant (PCA)** | **Durable Medical Equipment (DME)** | **Therapy** |
| Early Intervention | CarePlus Skilled Nursing | Augmentative and Alternative Communication Non-Dedicated Device | Occupational Therapy |
| Hearing Services | Home Health | Absorbent Products | Physical Therapy |
| Physician—Adult | PCA | DME—Other | Speech/Language Therapy |
| Physician—Pediatric | | Enterals | |
| Vision | | Mobility and Repairs | |
| Wigs | | Orthotics and Prosthetics | |
| Other | | Oxygen | |
| | | Personal Emergency Response System | |
| | | Standers | |

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| Item 4 | Member's Name, Address, and Tel. | Enter the member's name, address, and phone number (including area code). |
| Item 13 | Community Case Management (CCM) Member Identifier | Select "Yes" if the member for whom the service is being requested is enrolled in the CCM Program. CCM provides case management services to complex care members who need 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 member's eligibility in the MassHealth Eligibility Verification System (EVS) or by checking the eligibility panel of the Provider Online Service Center (POSC). On the POSC left side, select Manage Members, Verify Member, and then Eligibility. |
| Item 14 | Reason This Service Is Medically Necessary<br>Description of Treatment | Enter a statement explaining why the proposed service is medically necessary. Also include a description of the proposed treatment and prognosis. Refer to your MassHealth provider manual for additional information about this field.<br>ICD Diagnosis Code(s)<br>Enter the code from ICD-10 (for the most relevant diagnoses for the procedure or item being requested).<br>Description of Treatment<br>Enter a narrative of the proposed treatment. |
| Item 15 | Servicing Provider ID/Service Location or NPI | Enter the 9-digit servicing-provider ID followed by the one-character service location code. Write "same" if this is the same as requesting provider ID/service location. If that is not available, enter the provider's 10-digit NPI. |
| Item 16 | Service Code | Enter the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (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 at least 1) | Enter the number of times the service for which you are requesting PA will be furnished. |
| Item 18 | Attachments | Select "Yes" if additional information or supporting documentation is attached (refer to your provider manual); otherwise select "No." Make sure 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). |

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)

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| For PA requests for **basic medical services**, mail the Prior Authorization Request Form, with all necessary attachments, to the following address.<br>MassHealth<br>ATTN: Prior Authorization<br>100 Hancock Street, 6th Floor<br>Quincy, MA 02171 | For PA requests for **LTSS services**, mail the Prior Authorization Request Form, with all necessary attachments, to the following address.<br>MassHealth LTSS<br>PO Box 159108<br>Boston, MA 02215 |