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

Prior Authorization Request

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.	4. Member's Name, Address, and Tel. No.
Contact Name	5. Place of Residence: ☐ Home ☐ Nursing facility ☐ Rehab. hospital ☐ Other: _____
Contact Tel. No.	6. Height _____ ft. _____ in. | 7. Weight _____ lb. _____ oz.
Contact Email	8. Gender ☐ M ☐ F | 9. Other Insurance ☐ Yes ☐ No
Contact Fax	10. Full Name of Insurance Carrier
2. Provider ID/Service Location or NPI	11. Date of Birth / / | 12. Member ID
3. PA Assignment	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.)
A			
B			
C			
D			
E			

18. Attachments	19. Date PA Requested	20. Requested Effective Date	21. Requested End Date
☐ Yes ☐ No	/ /	/ /	/ /

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)

Print Clear

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	LTSS		
	Home Health/Personal Care Attendant	**Durable Medical Equipment**	**Therapy Services**
Early Intervention	CarePlus Skilled Nursing	AAC Non- Dedicated Device	Occupational Therapy
Hearing Services	Home Health	Absorbent Products	Physical Therapy
Physician-Adult	Personal Care Attendant (PCA) Services	DME–Other	Speech/Language Therapy
Physician-Pediatric		Enterals	
Vision		Mobility and Repairs	
Wigs		Orthotics and Prosthetics	
Other		Oxygen	
		PERS	
		Standers	

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 Member Identifier	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