PCA Prior Authorization Adjustment Form

☐ Increase
☐ Decrease

PCA Consumer | MassHealth ID No. | PCM Agency | PA No.

Current Authorization					Requested Authorization				Total adjustment request	
Specify activity ADL/ IADL	PCA time in minutes	Frequency		Total minutes per week currently authorized	PCA time in minutes	Frequency		Total minutes per week currently authorized	Requested minutes per week minus current minutes per week	Comments
		Times per day	Days per week			Times per day	Days per week			
					Total requested adjusted weekly day/evening PCA hours					

Specify 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		Total billable hours per night	Requested billable hours per night minus current billable hours per night	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.)

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

Additional comments (Attach additional sheets and supporting documentation as necessary.):

☐ I have reviewed this adjustment request: in person/over the telephone (circle one)

☐ I have reviewed this adjustment request with the consumer. Review date: _____

Signature of Requesting PCM Agency Reviewer Title Date

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

Requesting an adjustment from (Check and complete all that apply.)

☐ _____ hours to _____ day/evening hours per week

☐ _____ hours to _____ day/evening hours per week

☐ _____ (date) to _____ (date)

A cover letter must include the reason for the adjustment request. Specify what has changed for the consumer and how this change impacts the need for physical assistance with ADLs or IADLs.

Section 3: Physician/Nurse Practitioner Signature/Comments

Section 3 must be completed by the consumer's physician or nurse practitioner in lieu of a letter of medical necessity from the physician or nurse practitioner.

Requesting an adjustment from (Check and complete all that apply.)

☐ _____ hours to _____ day/evening hours per week

☐ _____ hours to _____ hours per night

Physician or nurse practitioner comments (attach additional sheets as necessary):

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 Physician or Nurse Practitioner Date

Print physician or nurse practitioner name, address, and telephone number:

Reset