

Instructions for completing the Preauthorization Request Form for Durable Medical Equipment Disposable Medical Supplies, and Oxygen and Respiratory Equipment (DHMH-4527)

The header above Section I assists DHMH staff to properly categorize and process your request. Proper categorization facilitates timely processing. These categories include Durable Medical Equipment, Disposable Medical Supplies, and Oxygen and Related Respiratory Equipment. If you are requesting items from more than one category, please use a separate form for each category. (i.e. Requests for diapers should be on a separate form when also requesting equipment)

Section I – Recipient Information

Section I identifies the intended recipient of the requested supplies or equipment. Please complete this section in its entirety ensuring the name of the recipient matches the data you provide. To make sure you are identifying the correct Medicaid fee-for-service eligible recipient, it is essential for you to consistently use the Eligibility Verification System (1-866-710-1447). If the recipient identified is not eligible for the Medicaid services requested, the preauthorization cannot be approved.

Section II – Preauthorization General Information

Section II identifies the provider offering to dispense the equipment or supplies. Each portion of this section is equally important. An accurate provider number, name and address ensure payment to the correct provider. Identification of a contact person by name and telephone number is helpful to DHMH staff when additional information is required from the rendering provider.

Note: It is important that the “pay-to” or rendering provider is enrolled as a Maryland Medicaid Provider. If the provider is not enrolled with Maryland Medicaid, the preauthorization request cannot be approved. Should the provider wish to initiate the enrollment process, they must contact Provider Enrollment at 410-767-5340.

Section III – Prescriber’s Information

The prescribing provider’s name, address and telephone number must be submitted. Your request cannot be approved if the request form is not signed and dated by the prescriber; or if a copy of the prescriber’s signed order/prescription is not attached to the DHMH-4527. Additionally, the recipient’s diagnosis, prognosis and the medical justification for the requested item (s) must be provided. When completing the medical justification, the goal is simply to explain why the requested item(s) is medically necessary and why the Medicaid Program should reimburse for services. The simplest way to do so is to relate the need to the information provided immediately above in “Diagnosis and Present Condition”. When the requested item(s) replaces an existing item(s) the rationale and justification for the replacement needs to be explained on the DHMH-4527 or on the prescriber’s letterhead. The prescriber must also include the date of the recipient’s last face to face encounter.

Section IV – Preauthorization Line Item Information

Clearly identifying the item(s) for which preauthorization is requested helps to expedite a timely response from the Medicaid Program. Items should not be submitted with a miscellaneous HCPCS Procedure Code when one has been assigned, unless the units requested are over the allowed direct bill amount. Submission of such could delay the response to a request. When complete and accurate information is not provided, the preauthorization form cannot be approved which causes the undesirable result of delaying consumer receipt of requested items.

Note: If the patient is in a nursing home or hospital, he/she is not eligible to receive durable medical equipment or disposable medical supplies through the fee for service program. All services will be provided by the inpatient facility. If the recipient is scheduled to be discharged to his/her home and will need medical equipment and/or supplies to prevent re-institutionalization, please provide the date of the impending discharge and a copy of the signed discharge order.

Section V – Detailed Item Information

Section V is completed for requests of customized items or items requiring individual consideration. For customized items, it is necessary to attach a specification/product sheet from the manufacturer, including the manufacturer's price, address, telephone number and provider number. It is also very important to fill-in the "Single Unit Cost" section with the manufacturer's suggested retail price.

Note:

- Search your records carefully for duplicate requests. The Program does not approve duplicate or similar items.
- Home assessments for mobility equipment (excluding standard wheelchairs) **must** accompany the DHMH-4527.

Completed forms are to be **mailed** to:

Office of Systems, Operations & Pharmacy
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

Resubmitted requests (PA number already assigned) are to be mailed to:

Department of Health and Mental Hygiene
Division of Community Support Services
201 West Preston Street, Room 136
Baltimore, Maryland 21201

If you have any questions pertaining to the completion of the DHMH-4527 or if you require additional training you may reach the Division of Community Support Services at 410-767-1739.

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREPAYMENT REQUEST FORM

Date (00/00/00)
| | | | | | | |

Please check appropriate box:
 DME DMS OXYGEN & RELATED RESPIRATORY EQUIP.

SECTION I – RECIPIENT’S INFORMATION

Recipient’s Maryland Medicaid Number
| | | | | | | | | | | |

NAME (Last) (First) (MI)

DOB SEX TELEPHONE NO.

Address
City State Zip Code

SECTION II – PAY-TO-PROVIDER INFORMATION

Maryland Medicaid Provider Number National Provider Identifier (NPI)

Provider Name & Address: _____
Contact: _____ Telephone: () _____

SECTION III – PRESCRIBER’S INFORMATION

Date of Request: _____ Date of last face to face encounter by prescriber: _____
Name: _____ Telephone: () _____
Address: _____
Prescriber’s Signature: _____

TO BE COMPLETED BY PRESCRIBER: _____ LMN Attached Length of Need: _____

Diagnosis and Present Physical Condition: _____

Medical Justification (be specific): _____

Prognosis: _____

Note: If appropriate item type block is not checked, form will be returned. DME/DMS cannot be on same form. CPAP requests require sleep apnea studies or PFT’s.

AUTHORIZATION NUMBER

| | | | | | | |

SUBMIT TO: Office of Systems Operations & Pharmacy
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

**MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREPAYMENT REQUEST FORM**

SECTION IV – PREPAYMENT LINE ITEM INFORMATION

	NAME OF ITEM	PROCEDURE CODE	* MISC CODE	DATES OF SERVICE		REQUESTED	
				FROM	THRU	UNITS	AMOUNT
1.	_____	_____	_____	___/___/___	___/___/___	_____	\$ _____
2.	_____	_____	_____	___/___/___	___/___/___	_____	\$ _____
3.	_____	_____	_____	___/___/___	___/___/___	_____	\$ _____
4.	_____	_____	_____	___/___/___	___/___/___	_____	\$ _____
5.	_____	_____	_____	___/___/___	___/___/___	_____	\$ _____
6.	_____	_____	_____	___/___/___	___/___/___	_____	\$ _____

* To be used when requesting overages

SECTION V – DETAILED ITEM FOR MEDICAL EQUIPMENT AND SUPPLIES

	MFR	MODEL/PRODUCT NUMBER	SINGLE UNIT COST	UNITS PER PKG
1.	_____	_____	\$ _____	_____
2.	_____	_____	\$ _____	_____
3.	_____	_____	\$ _____	_____
4.	_____	_____	\$ _____	_____
5.	_____	_____	\$ _____	_____
6.	_____	_____	\$ _____	_____

Notes:

All equipment purchased by the Department for the patient’s use remains the property of the Department of Health and Mental Hygiene (COMAR 10.09.12.07O), therefore should be recycled whenever possible. Please contact the Program at 410-767-1739 to request the required state identification tags to place on the equipment.

Equipment can not be donated or given away, unless authorized by the Program.

All requests for mobility equipment (excluding standard wheelchairs) must have home assessment form attached.

It is the provider’s responsibility to:

Verify recipient’s eligibility before dispensing items

Ensure that the recipient (or legal guardian) is aware of his/her responsibility to contact the Medical Medicaid Provider when equipment is no longer needed

Ensure that the recipient and/or caregivers are informed of the proper use of all equipment provided

Notify the Program of any suspected fraud by calling 866-770-7175

Please take the time to visit our website: <http://dhmh.state.md.us/mma/communitysupport/>