Prior Authorization Request
Hewlett Packard Enterprise - Nevada Medicaid and Nevada Check Up

Durable Medical Equipment

Fax this request to: (866) 480-9903 For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

REQUEST TYPE: ☐ Initial ☐ Continued Services ☐ Retrospective ☐ Unscheduled Revision

REQUIRED FOR RETROSPECTIVE REQUESTS ONLY
This recipient was determined eligible for Medicaid benefits on: _____ /_____ /_____

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Address:	Phone:	
City:	State:	Zip Code:

INSURANCE INFORMATION
Medicare: ☐ Part A ☐ Part B ID#: _____ Other Insurance: _____
Additional Comments:_____
Does this recipient meet the standard Medicare criteria for the requested items? ☐ Yes ☐ No
(If "No," PA will be processed. The provider agrees to obtain a signed ABN for any service Medicare does not cover due to medical necessity.)

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:		
Address:	Phone:	Fax:
City:	State:	Zip Code:

SERVICING PROVIDER INFORMATION

Servicing Provider Name:		
NPI:		
Address:	Phone:	Fax:
City:	State:	Zip Code:
Contact Name:		

CLINICAL INFORMATION

Enter up to four ICD codes that apply: _____ _____ _____ _____
Additional Clinical Information: _____
_____
_____
_____
_____

Durable Medical Equipment

In the table below, use column 1 to enter the HCPCS code. Check column 2 if no HCPCS code is assigned from PDAC for the item being requested. Use column 3 to enter a description of the item. Enter the appropriate modifier and number of requested units in columns 4 and 5. In column 6, enter "R" if the equipment is for rent and "P" if the equipment is for purchase. If the item is covered by Medicare, enter a "Y" in column 7. If the item is not covered by Medicare, enter an "N" in column 7. Enter the requested "Start" and "End" dates for each item in columns 8 and 9. Column 10 is for Hewlett Packard Enterprise use only.

1	2	3	4	5	6	7	8	9	10
HCPCS CODE	No HCPCS code	DESCRIPTION	MODIFIER	UNITS	"R" or "P"	MEDICARE Y or N	START DATE	END DATE	**FOR HEWLETT PACKARD ENTERPRISE USE ONLY**

Is this request for Healthy Kids (EPSDT) services? ☐ Yes ☐ No

REQUIRED FOR NURSING FACILITY (NF) PATIENTS AND PATIENTS BEING DISCHARGED FROM A NF:
Enter the date the recipient was or will be discharged from the nursing facility: _____ /_____ /_____

ORDERING PHYSICIAN'S SIGNATURE:

PRINT NAME: **DATE:** _____ /_____ /_____

THE FOLLOWING FOUR ITEMS MUST BE ATTACHED TO THIS FORM: (1) documentation of medical necessity from the servicing provider (2) a medical order from the servicing provider (3) a copy of the signed prescription and (4) a copy of the equipment manufacturer's invoice, when applicable.

FOR HEWLETT PACKARD ENTERPRISE USE ONLY

Authorization Number: _____ Processing Date: _____

☐ Rejected	This request was rejected due to: ☐ Insufficient Information ☐ Late Notification Rejection Date: _____ /_____ /_____

Reviewer's Signature: _____ Date: _____ /_____ /_____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.