



719A Prior Authorization Request

Patient			Prescribing Provider		Servicing Provider		
Beneficiary Name			Provider Name		Provider Name		
DCID Number			Provider Number	NPI	Provider Number	NPI	
Address City, State, Zip			Address City, State, Zip		Address City, State, Zip		
Telephone Number	DOB	SEX	Telephone Number		Telephone Number		
Other Health Insurance Coverage			Requested Service			Beneficiary Location	
			Surgery <input type="checkbox"/>	DME <input type="checkbox"/>	Home <input type="checkbox"/>		
			Medical <input type="checkbox"/>	Pharmacy <input type="checkbox"/>	ICF/MR <input type="checkbox"/>		
			Dental <input type="checkbox"/>	Eyewear <input type="checkbox"/>	Nursing Home <input type="checkbox"/>		
			Hospice <input type="checkbox"/>	Other <input type="checkbox"/>	Hospital <input type="checkbox"/>		
Discharge Date:			Home Health: <input type="checkbox"/> Skilled Nurse <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> HHA <input type="checkbox"/> Private Duty			Office <input type="checkbox"/>	

Requested Service Data					
Diagnosis Code	Procedure Code	Description of Services, DME and Supplies	Time Required	Frequency or Units	Estimated Charges

Justification

For Dental Use only

DENOTE THE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY "?", X-RAYS TAKEN BY "V"

Q1	FACIAL			FACIAL			Q2								
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
R	PRIMARY TEETH			A	B	C	D	E	F	G	H	I	J	PRIMARY TEETH	
I				LINGUAL			LINGUAL			PRIMARY TEETH			L		
G				T	S	R	Q	P	O	N	M	L	K	PRIMARY TEETH	
H													PRIMARY TEETH		E
T													PRIMARY TEETH		F
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Q4	FACIAL			FACIAL			FACIAL			FACIAL			PRIMARY TEETH		Q3

For DME, Home Health, Private Duty Use Only

**Requesting Physician Certification:** I certify that I have documented that a Face-to-Face encounter, related to the primary reason the beneficiary requires Home Health or DME services, occurred on \_\_\_\_\_ between the beneficiary and the allowed prescriber (listed below).

Primary Physician     Nurse Practitioner     Certified Nurse Mid-Wife     Physician Assistant     Acute or Post-Acute Physician

Name of allowed prescriber: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Durable Medical Equipment Face to Face Regulations

Any HCPCS code for the following types of DME: ++Transcutaneous Electrical Nerve Stimulation (TENS) unit    ++Rollabout Chair    ++Traction-cervical

++Oxygen and Respiratory equipment    ++Hospital beds and accessories

Any item of DME that appears on the DMEPOS Fee Schedule with a price ceiling at or greater than \$1,000.

Any other item of DME that CMS adds to the list of Specified Covered Items

**Signature of the Requesting Provider:** I Certify that the services requested are medically indicated and necessary for the health of this patient and that the foregoing information is true, accurate, and complete.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

DATE