NC DHB Request for Prior Approval CMN/PA

Recipient Information **DMA372-131 V1.0**

1. Recipient Last Name:___________________________ 2. First Name:___________________________

3. Recipient ID #____________________ 4. Recipient Date of Birth:_______________ 5. Recipient Gender:_________

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting Provider #:____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____________________

9. Address: ____ 10. Nine Digit Zip Code: _________________

11. Billing Provider # (if different from requesting):_______________________NPI: ☐ Atypical: ☐ 12. Taxonomy: ______________________

13. Address: ____ 14. Nine Digit Zip Code: _________________

15. Rendering Provider # (if different from billing):_______________________NPI: ☐ Atypical: ☐ 16. Taxonomy: _____________________

17. Address: ____ 18. Nine Digit Zip Code: _________________

Requester Contact Information Name:__________________________________ Phone #:_____________________ Ext:_______

Medical and Functional Status

19. **Condition:** Stable: ☐ Unstable: ☐ Height: _________ Weight: ________

20. **Prognosis:** Terminal: ☐ Poor: ☐ Guarded: ☐ Fair: ☐ Good: ☐ Excellent: ☐

21. **Patient:** Requires positioning not feasible in ordinary bed: ☐ Unattended for long periods of time: ☐ Lives alone: ☐

22. **Equipment:** Necessary to retard deterioration of condition: ☐ Necessary for function: ☐ Specify_____________ Length of need: ______

23. **Mental:** Oriented: ☐ Forgetful: ☐ Disoriented: ☐ Agitated: ☐ Comatose: ☐ Depressed: ☐ Lethargic: ☐ Infant: ☐ Other: ______

24. **Neurological:** Muscle Tone: Normal: ☐ Increased: ☐ Decreased: ☐ Fluctuating: ☐
Sensation: Normal: ☐ Abnormal: ☐ Specify:___________

25. **Respiratory:** Normal: ☐ SOB on minimal exertion: ☐ Tracheostomy: ☐
O2: ☐ Flow Rate:________ Frequency: __________ Test Date: ___________ Results: ______________

26. **Skin:** Normal: ☐ Other: ☐ Specify: ____________ Decubiti: ☐ Specify: ___________________

27. **Ambulatory:** Complete bedrest: ☐ Up as tolerated: ☐
Transfers bed-chair (indep): ☐ Transfers bed-chair (w/assistance): ☐ Confined to wheelchair? ☐ Hours per day: _____
Walks unassisted: ☐ Walks with assistive device: ☐ Specify: ____________ Max distance walked: __________

28. Can place of residence physically accommodate equipment being requested? ☐ Yes ☐ No

29. Patient's status will be monitored by physician while assistance is provided? ☐ Yes ☐ No

30. Medical Necessity of equipment: ____

____

____

Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

_______________________ _________ ___________ _______________________ ______________ ___________

Requesting Provider's Signature Date Physician, PA, Nurse Practitioner Signature Date

~~Fax this form to: (855) 710 1964~~