COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAMS

OUTPATIENT SERVICES AUTHORIZATION REQUEST
MA 97

Detailed instructions for completing the MA 97 for either prior authorization - or - 1150 Waiver are on the reverse of this sheet for your convenience as they relate to each section of the form.

When the form is completed, remove this sheet at the perforation. Then, remove the first copy of the MA 97 and send it to the appropriate address as indicated below. For those services which require a prescription, attach a copy of the Rx to the MA 97. Retain the second copy for your record.

FOR SHIFT NURSING OUTPATIENT SERVICES, SEND TO:

OUTPATIENT
PA / 1150 WAIVER SERVICES
PO BOX 8188
HARRISBURG, PA 17105-8188

FOR ALL OTHER OUTPATIENT SERVICES, SEND TO:

OUTPATIENT
PA / 1150 WAIVER SERVICES
PO BOX 8188
HARRISBURG, PA 17105-8188

PLEASE TURN TO INSTRUCTIONS ON REVERSE

GUIDELINES FOR COMPLETING THE OUTPATIENT SERVICE AUTHORIZATION REQUEST FORM (MA97)

Items 1 & 2 Prior Authorization/1150 Waiver (Program Exception) (MUST, IF APPLICABLE)

Place a check (✓) in the appropriate box for the type of request. Check only ***one*** box per MA 97. If both types of requests are required, ***separate MA 97s*** must be completed for each type of request.

PATIENT INFORMATION

Items 3 through 6 are to be completed using information obtained from the Eligibility Verification System (EVS).

Item 3 Recipient Number (MUST)

Enter the 10-digit recipient identification number.

Item 4 Patient's Name (Last, First, MI) (MUST)

Enter the recipient's last name, first name, and middle initial (if any).

Item 5 Birthdate (mmddccyy) (MUST)

Enter the recipient's birthdate in an 8-digit format.

Item 6 Sex (OPTIONAL)

Check the appropriate box, "M" (male) or "F" (female).

PROVIDER/PRESCRIBER INFORMATION

Items 7 through 11 are to be completed using the information found on the provider's PROMISe™ Provider Enrollment Notice Information.

Item 7 Provider Name (MUST)

Enter the provider's last name, first name, and middle initial (if any).

Item 8 Provider ID (MUST)

Enter the provider's 13-digit PROMISe™ Provider ID Number.

Item 9 Provider's Own Reference No. (OPTIONAL)

Enter your own reference number or recipient's name to comply with the provider's filing system.

Items 10 through 11 will only be completed if the payment for services will be sent to someone other than the provider of services. A group/payee must be enrolled with DPW.

Item 10 Group (Payee) Name (MUST, IF APPLICABLE)

Enter the name of person, group, or organization designated to receive payment.

Item 11 Group ID NUMBER (MUST, IF APPLICABLE)

Enter the payee's 13-digit PROMISe™ Provider ID Number.

Items 12 through 15 refer to the Referring Practitioner/Prescriber, if applicable.

Item 12 Name of Referring Practioner or Prescriber (MUST, IF APPLICABLE)

Enter the name of the referring practioner/prescriber, if applicable. Enter the first name, middle initial (if any) and last name, followed by degree.

Item 13 License Number (MUST, IF APPLICABLE)

Item 14 Telephone Number (MUST, IF APPLICABLE)

Enter the referring practitioner's/prescriber's telephone number, including area code. The referring/prescribing practitioner may be contacted if additional information is needed by DPW.

Item 15 Practitioner's/Prescriber's Street Address/City/State/Zip Code (MUST, IF APPLICABLE)

Enter the referring practioner's/prescriber's street address to which the approval or itemized notice is to be mailed. Make sure the address is correct and complete.

Item 16 Primary Diagnosis (MUST)

Enter the recipient's primary diagnosis. For dental services, this item is LEAVE BLANK.

Item 17 ICD-9-CM Diagnosis Code (MUST)

Enter the ICD-9-CM Diagnosis Code that corresponds to the primary diagnosis entered in item 16. For Mental Health requests, use the DSM-IV Code. For dental services, this item is LEAVE BLANK.

Item 18 Secondary Diagnosis (MUST, IF APPLICABLE)

If applicable, enter the recipient's secondary diagnosis. For dental services, this item is LEAVE BLANK.

Item 19 ICD-9-CM Diagnosis Code (MUST, IF APPLICABLE)

Enter the ICD-9-CM Diagnosis Code that corresponds to the secondary diagnosis entered in item 18. For Mental Health requests, use the DSM-IV Code. For dental services, this item is LEAVE BLANK.

REQUESTED SERVICES (Items 20A through 29)

When requesting a single item or service, complete the appropriate items in Items 20A through 20G as follows:

Item 20A Description of Services/Supplies Requested (MUST)

Enter a description of the service/equipment/item, or use the DPW procedure name terminology found in the MA Program Fee Schedule. For dental services, use the appropriate CDT-4 procedure name terminology and procedure code, if available.

Prior Authorized Services Only (Item 1 was checked)

Item 20B Procedure Code (MUST, IF AVAILABLE)

Enter the 5-digit procedure code, if available, for the service/equipment/item requested. For dental services, this item is LEAVE BLANK.

Item 20C Must if applicable. Indicate pricing modifiers in block 1. If no pricing modifiers are needed, then enter additional modifiers starting with block 1. Use blocks 2, 3 and 4 to report any additional modifiers.

Item 20D Quantity (MUST)

Enter the exact units of service or number of items being requested. For dental services, this item is LEAVE BLANK.

1150 Waiver Services Only (Item 2 was checked)

Item 20E Amount Per Unit (MUST)

Enter the exact dollar amount requested for each service requested.

Item 20F Quantity Per Unit (MUST)

Enter the exact quantity of services requested for each month.

Item 20G Number of Months (MUST)

Enter the number of months for which the services are requested. For dental services, this item is LEAVE BLANK.

Items 21 through 25 are available for additional requested services/equipment /items and must be competed as described in 20A through 20G. **NOTE:** *FOR PRIOR AUTHORIZATION **ONLY**, USE ONE LINE FOR EACH MONTH BEING REQUESTED.*

Item 26A Estimated Length of Need (No. of Months) (MUST, IF APPLICABLE)

If the service will be needed over a period of months, enter the # of months the recipient is expected to need the services. Enter 1-99 (99=Lifetime).

Item 26B Initial Date of Service (MMDDCCYY) (MUST, IF APPLICABLE)

Enter the date the most recent uninterrupted service period began. For dental services, this item is LEAVE BLANK.

Item 26C Beginning Date of Service for This Request (MMDDCCYY) (MUST)

Enter the date that the service being requested is scheduled to begin using an 8-digit format. If the service will be provided only once, enter the date the service will be provided.

Item 27 What Other Alternatives Have Been Tried or Used to Meet This Patient's Needs? (MUST).

Attach documentation, as needed, of alternatives which have been tried and justify the need for the service(s) requested - 20A through 25H. If no alternatives have been tried or used, indicate "N/A".

Item 28 Check the Box Which Applies to This Patient's Current Residential Status (MUST).

Check the appropriate box to indicate where the recipient resides.

Item 29 Give a Narrative Description of the Specific Symptoms or Abnormalities the Service/Equipment/Supplies are Intended to Alleviate. Provide the Medical Justification Needed for the Evaluation of This Request. (MUST)

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½ x 11.

For dental services, the Program Exception request must be performed as part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

1. pertinent dental history;
2. pertinent medical history, if applicable;
3. the strategic importance of the tooth;
4. the condition of the remaining teeth;
5. the existence of all pathological conditions;
6. preparatory services performed and completion date(s);
7. documentation of all missing teeth in the mouth;
8. the oral hygiene of the mouth;
9. all proposed dental work;
10. identification of existing crowns, periodontal services, etc.;
11. identification of the existence of full and/or partial denture(s), with the date of initial insertion;
12. the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
13. identification of abutment teeth by number.

NOTE: *FOR THOSE SERVICE PROGRAMS WHERE DENTAL SERVICES ARE LIMITED TO SERVICES PROVIDED IN AN INPATIENT HOSPITAL, HOSPITAL SHORT PROCEDURE UNIT OR AMBULATORY SURGICAL CENTER, PLEASE INCLUDE A STATEMENT IDENTIFYING WHERE THE SERVICE WILL BE PROVIDED.*

When requesting Mental Health services, all of the following clinical information from the prescribing mental health professional (psychologist/psychiatrist) is essential in order to establish the clinical necessity for the services:

1. current psychological/psychiatric evaluation including DSM-IV ACIS I-V (within 30 or 45 days from date of request);
2. current treatment plan;
3. plan of care summary;
4. service description (unless approved and on file; attach copy of approval letter)

Item 30 Number of Attachments (MUST, IF APPLICABLE)

Indicate the number of attachments, including radiographs, that are being submitted with the MA 97. For example, if you attached two additional pages to include additional treatment plan information and a Panorex, you would enter a "3".

Item 31 & 32 Inital Request/Resubmission of Previously Denied Request (MUST, IF APPLICABLE)

If this is the initial request, enter an "X" in Item 31. If this is a resubmission of a previously denied request, enter an "X" in Item 32 and the previously denied Prior Authorization/Program Exception Reference Number from the "Prior Authorization Notice" or "Program Exception Notice" in the space provided.

Item 33 Signature of Patient/Authorized Representative (MUST)

The patient or authorized representative MUST sign the MA 97.

Item 34 Date (MUST)

The patient or authorized representative must enter the date the MA 97 was signed in 8-digit format (mmddccyy).

Item 35 Practioner's/Prescriber's Signature (MUST)

It is essential that the practioner requesting the service/item sign or use his/her signature stamp on the MA 97.

Item 36 Date (MMDDCCYY) (MUST)

The practitioner must enter the date the MA 97 was completed in 8-digit format.

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LEAVE THIS AREA BLANK

OUTPATIENT SERVICES AUTHORIZATION REQUEST

1 ☐ PRIOR AUTHORIZATION 2 ☐ 1150 WAIVER (PROGRAM EXCEPTION)

PATIENT INFORMATION

3 RECIPIENT NUMBER	4 PATIENT LAST NAME	FIRST NAME	M.I.	5 BIRTHDATE	6 ☐ M ☐ F

PROVIDER / PRESCRIBER INFORMATION

7 PROVIDER NAME	8 PROVIDER ID	9 PROVIDER'S OWN REFERENCE NUMBER
10 GROUP NAME	11 GROUP ID NUMBER	
12 NAME OF REFERRING PRACTITIONER OR PRESCRIBER	13 LICENSE NUMBER	14 TELEPHONE NUMBER

15 PRACTITIONER'S / PRESCRIBER'S STREET ADDRESS	CITY	STATE	ZIP CODE

16 PRIMARY DIAGNOSIS	17 ICD-9CM/DSM-IV CODE	18 SECONDARY DIAGNOSIS	19 ICD-9CM/DSM-IV CODE

REQUESTED SERVICES

A DESCRIPTION OF SERVICES/SUPPLIES REQUESTED	FOR PRIOR AUTHORIZED SERVICES ONLY						FOR 1150 WAIVER ONLY		
	B PROCEDURE CODE	C MODIFIER MOD 1	MOD 2	MOD 3	MOD 4	D QUANTITY	E AMOUNT PER UNIT	F QUANTITY PER MONTH	G NUMBER OF MONTHS
20									
21									
22									
23									
24									
25									

26 A ESTIMATED LENGTH OF NEED (No. of Months): 1-99 (99= Lifetime) ▶ B INITIAL DATE OF SERVICE ▶ C BEGINNING DATE OF SERVICE FOR THIS REQUEST ▶

27 WHAT OTHER ALTERNATIVES HAVE BEEN TRIED OR USED TO MEET THIS PATIENT'S NEEDS?

28 CHECK THE BOX WHICH APPLIES TO THIS PATIENT'S CURRENT RESIDENTIAL STATUS:
☐ LONG TERM CARE ☐ MENTAL HEALTH ☐ RESIDENTIAL ☐ FOSTER CARE ☐ INPATIENT HOSPITAL ☐ HOME
☐ OTHER IF IN A FACILITY, PLEASE LIST THE NAME TO THE RIGHT_____

29 GIVE A NARRATIVE DESCRIPTION OF THE SPECIFIC SYMPTOMS OR ABNORMALITIES THE SERVICE/EQUIPMENT/SUPPLIES ARE INTENDED TO ALLEVIATE. PROVIDE THE MEDICAL JUSTIFICATION NEEDED FOR THE EVALUATION OF THIS REQUEST.

30 NUMBER OF ATTACHMENTS ▶

31 ☐ INITIAL REQUEST

32 ☐ RESUBMISSION OF PREVIOUSLY DENIED REQUEST
ENTER DENIED PA/PE REFERENCE NUMBER

I ATTEST THAT IN MY PROFESSIONAL JUDGEMENT, ACTING WITHIN THE SCOPE OF MY PROFESSIONAL TRAINING AND CERTIFICATION, THAT THE PRESCRIBED SERVICE AS DEFINED ON THIS FORM IS MEDICALLY NECESSARY AND THAT THE INFORMATION PROVIDED AND STATEMENTS MADE HEREIN ARE TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

I AUTHORIZE RELEASE OF INFORMATION RELATIVE TO THIS REQUEST

33 SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE 34 DATE

35 PRACTITIONER / PRESCRIBER SIGNATURE 36 DATE

DPW COPY

PROVIDER COPY