ATTACHMENT J.18

SAMPLE COMPLETED 719A FORM

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM

BILLING PROVIDER: ABC MEDICAL SUPPL
PROVIDER NUMBER: 023435100

558152

PRIOR AUTHORIZATION REQUEST/APPROVAL

1 PATIENT				2 REQUESTING PROVIDER			
A. RECIPIENT D.C. I.D. NUMBER 1234567 digits				A. PROVIDER NUMBER 123456789 digits			
B. NAME (LAST, FIRST, M.I.) PRINT Doe, Jane A.				B. NAME (LAST, FIRST, M.I.) PRINT Doe, John MD			
C. ADDRESS 1234 Street, City, Sate, zip code				C. ADDRESS 1234 Street			
D. TELEPHONE NUMBER XXX-XXX-XXXX	E. DATE OF BIRTH mm/dd/yyyy	F. SEX ☐ M ☐ F		D. CITY City, State zipcode	STATE	ZIP	E. TELEPHONE NUMBER XXX-XXX-XXXX

3 OTHER HEALTH INSURANCE COVERAGE	4 REQUESTED SERVICE				5 PATIENT LOCATION	
ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY. IF NONE PLEASE INDICATE. N/A	SURGERY	☐	MEDICAL SUPPLIES OR EQUIPMENT	☐	HOME	☐
	MEDICAL	☐	TRANSPORTATION	☐	ICF/MR	☐
	DENTAL	☐	EYEWEAR	☐	NURSING HOME	☐
			OTHER	☐	HOSPITAL INPATIENT	☐
					DISCHARGED DATE:	

REQUESTED SERVICE DATA

6 DIAGNOSIS CODE	7 PROCEDURE CODE	8 DESCRIPTION OF SERVICES, DURABLE MEDICAL EQUIPMENT OR SUPPLIES	9 TIME REQUIRED	10 FREQ OR UNITS	11 ESTIMATED CHARGE ($)	12 APPROVED AMOUNT ($)
780.53	K0011	MOTORIZED WHEELCHAIR		1	$1170.	

13 JUSTIFICATION
GAIT STABILITY DUE TO STATUS EPILEPTICUS

DOS: 8/2/07

14 FOR DENTAL USE ONLY
DENOTE TEETH ALREADY MISSING BY "X", TO BE EXTRACTED BY "E", X-RAYS TAKEN BY "V"

Q1																	Q2
			FACIAL									FACIAL					
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16		
A		PRIMARY TEETH											PRIMARY TEETH		L		
I			AA	BB	CC	DD	EE	FF	GG	HH	II	JJ			E		
G			LINGUAL								LINGUAL				F		
H			TT	SS	RR	QQ	PP	OO	NN	MM	LL	KK			T		
T																	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
Q4			FACIAL								FACIAL				Q3		

15 A. SIGNATURE OF REQUESTING PROVIDER — I CERTIFY THAT THE SERVICES REQUESTED ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.
Physician signature required

B. DATE
8/1/2007

DO NOT WRITE BELOW THIS LINE

ACTION

DISAPPROVED	APPROVED AMOUNT $ _____	PRIOR AUTHORIZATION NUMBER	SIGNE	DATE

COMMENTS _____

SUBMIT ORIGINAL AND 1 (ONE) COPY TO D.C. DEPT OF HUMAN SERVICES. IF SERVICE IS APPROVED TRANSCRIBE PRIOR AUTHORIZATION APPROVAL NUMBER TO BILLING FORM. SUBMIT BILLING FORM TO ADDRESS SHOWN IN BILLING MANUAL.

DHS 719A (REVISED 3/81)