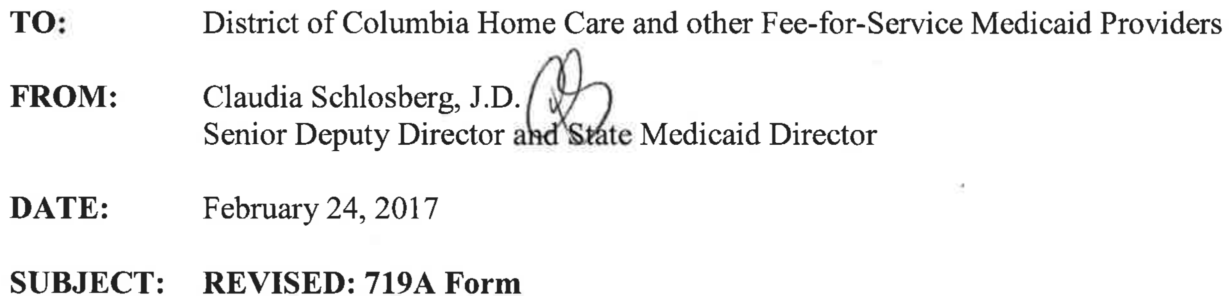
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 17-06**



TO: District of Columbia Home Care and other Fee-for-Service Medicaid Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: February 24, 2017

SUBJECT: REVISED: 719A Form

The Department of Health Care Finance (DHCF's) 719A form is used to request an authorization for medical/surgical service(s), for the Fee-for-Service (FFS) Medicaid beneficiaries. The 719A has been revised, and will be in effect starting March 1, 2017. The new 719A form incorporates the CMS requirement that a physician or nurse practitioner certify a face-to-face encounter, when ordering home care services and Durable Medical Equipment (DME). Moving forward, all sections of the 719A form must be completed in its entirety, hence the removal of specific numbered sections as specified in preceding transmittals.

The revisions are as follows:

- Addition of the Face-to-Face certification section for Home Care and DME
- Addition of Pharmacy and Hospice to the Requested Services section
- Corrections to the dental section
- Alignment of the prescribing and servicing provider sections
- Addition of the NPI section (both the DC provider ID and the NPI are required)
- Addition of the discharge date, if the beneficiary is in a treating facility at the time of the prior authorization request

If you have questions about these changes, please contact Cavella Bishop, Program Manager for the Division of Clinicians, Pharmacy, and Acute Provider Services via e-mail at cavella.bishop@dc.gov.

cc: Medical Society of the District of Columbia
DC Hospital Association
DC Health Care Association
DC Primary Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

Government of the District of Columbia
Department of Health Care Finance
Fee-For-Service Medicaid Program

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	☐	DME	☐	Home	☐
	Medical	☐	Pharmacy	☐	ICF/MR	☐
	Dental	☐	Eyewear	☐	Nursing Home	☐
	Hospice	☐	Other	☐	Hospital	☐
Discharge Date:	**Home Health:** ☐ Skilled Nurse ☐PT ☐OT ☐SLP ☐HHA ☐Private Duty				Office	☐

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