**EPDW Prior Authorization (PA) Request Notification**

Please use the table below to enter the PA request(s) that you are requesting DHCF/LTCA for transfer (this is in lieu of tasking in Casenet). After the transfer documents have been imported, please enter the recipient(s’) name(s) and information in the table below. Then email this “PA Request Notification” form to [DHCFLTCAProvider@dc.gov](mailto:DHCFLTCAProvider@dc.gov) and identify the discharging provider’s name and type of request in the email subject line (e.g. United Health Care Request for PCA Transfer). Please conduct a comprehensive quality assurance (QA) review on each document prior to importing into Casenet. If the transfer form and related documents (PCP and Discharge Plan) are incomplete, or contain inaccurate information, the PA will not be processed.

***Note: The discharging provider agency must continue to provide and administer care services to their client(s) until the receiving provider agency is issued an approved PA. If the transfer request is for case management services and the recipient’s eligibility is expiring within 90 days (or less) the discharging case management provider is required to complete the recertification including a PCP (person centered plan).***

Name of Case Management Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **No.** | **Recipient’s Name** | **Medicaid ID** | **Type of Request**  **(CM, PCA, PERS, Respite, etc.)** | **Start of Care Date** | **Discharging Provider Agency (CMA, DCA/HHA etc.)** | **Receiving Provider Agency** | **Notes/Comments** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  | |