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		04	05	06	07	08	09	10	11	12	13	14	15	16
R																L
I				A	B	C	D	E	F	G	H	I	J			E
G			PRIMARY TEETH	LINGUAL								LINGUAL		PRIMARY TEETH		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.	DATE
Signature:_____ Title:_____	