Prior Authorization Form - 719A

What is the 719A Form?

The 719A form is the physician's or authorized prescriber's written prescription for services and/or supplies. You will receive this form from the physician, authorized prescriber or the recipient.

All forms must be completed accurately to prevent processing delays or having the form returned to you. Upon receipt of the form, the following information should have been completed by the physician or authorized prescriber:

1. **Block 1** - Patient information
2. **Block 2** - Requesting provider information
3. **Block 6** - Diagnosis code
4. **Block 13** - Justification which should include the how the service will be used in the recipient's environment, including the recipient's or caregiver's ability, willingness and motivation to use the product and the requested date of service for the service/product.
5. **Block 15** - Must be signed and dated by the physician or authorized prescriber

If the above information is not on the form when it is received, it is the billing provider's responsibility to contact the physician and/or authorized prescriber to obtain the necessary information.

Determining Medical Necessity

Providers should consult the fee schedule to determine if the procedure code requires prior authorization.

Medical necessity or a medically necessary service is defined as medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related illness, condition or disability including services necessary to prevent a detrimental change in either medical, behavioral, mental or dental health status. Only supplies, equipment and appliances that are determined as medically necessary by the Department of Health Care Finance or its contracted representative are covered.

Services determined as medically necessary must be:

1. Appropriate to the individual's physical, mental, developmental, psychological, and functional health
2. Clinically appropriate in terms of type, frequency, extent, setting and duration
3. Reasonable and necessary part of the recipient's treatment plan
4. Not furnished for the convenience of the recipient's family, attending practitioner or other practitioner or supplier
5. Be necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational)
6. Be established as safe and effective for the recipient's treatment protocol
7. Be furnished at the most appropriate level that is suitable for use in the recipient's home environment

For general information about what is covered under the District's Medicaid Fee-for-Service program, as well as what is covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children; please refer to Section 13.0 of the provider handbook.

Required Documentation

In addition to confirming medical necessity, the following documents are required.

1. **Prior Authorization Form (PA 719A form):** This form is used by physicians and authorized prescribers to order durable medical equipment, supplies, and services and products (i.e., DME/POS, dental, optical) that are necessary to treat a health care condition. This serves as the recipient's prescription.
2. The **Letter of Medical Necessity** provides DC Medicaid with a visual image of the patient's needs. This letter is issued by the physician or authorized prescriber.
3. **Evaluation/Assessment** is submitted if necessary.
4. **Plan of Treatment** medically justifies the necessity for all supplies and equipment under this program and must be attached to the 719A form.

Completing the 719A – Prior Authorization Form

Billing provider

a. Enter the billing provider's Medicaid number.
b. Print the name of the billing provider who is requesting reimbursement for the service(s) or product(s) provided.

Block 1: Patient

a. Enter the recipient's 8-digit Medicaid number as it appears on the Medical Assistance Card.
b. Enter the recipient's name as it appears on the Medical Assistance Card.
c. Enter the recipient's address including street, city, state and zip code.
d. Enter the recipient's telephone number.
e. Enter the recipient's date of birth.
f. Select the appropriate box

Block 2: Requesting Provider

a. Enter the requesting provider's Medicaid number.
b. Enter the name of the practitioner requesting the service for the recipient
c. Enter the street address for the provider.
d. Enter the city, state, and zip code for the provider.
e. Enter the telephone number of the provider.

Block 3: Other health insurance coverage

a. Enter the name of the policy holder, plan name, address and policy of any third party reported by the recipient or known by the provider to cover the services being requested.
b. If not applicable, leave blank or enter "N/A".

Block 4: Requested service

a. Select the appropriate block for the requested equipment or service.

Block 5: Patient location

a. Select the block that appropriately describes the patient's location.
b. Enter the discharge date, if the patient is still in a facility.

Block 6: Diagnosis

a. Enter the appropriate diagnosis code from the ICD-9 CM that best reflects the patient's condition and describes the need for the service or equipment requested.

Block 7: Procedure code

a. Enter the HCPCS (procedure) code with the appropriate modifier (if applicable) of the equipment or service being requested.

Block 8: Description of services, durable medical equipment or supplies

a. Enter the description of the requested equipment or service as listed in the HCPCS Coding Manual.

Block 9: Time required

a. Enter best estimate

Block 10: Freq or units

a. Enter the number of services required or the number of items required to provide for the patient's needs.
b. The time the service is needed may exceed limits and require adjustments by the Department of Health Care Finance for the balance of time needed for the service.

Block 11: Estimated charge ($)

a. Enter the estimated customary and usual charge for the service or equipment.

Block 12: Approved amount ($)

a. The field is completed by the Department of Health Care Finance or its contracted representative with the allowed reimbursement amount.

Block 13: Justification

a. Enter medical justification for the equipment or supplies to be provided.
b. Enter the date of service for the requested product or service.

Note:

a. Do not enter the ICD-9 CM code.
b. When requesting additional equipment accessories (i.e., a standard wheelchair) include height and weight, if the equipment is for extra heavy, extra tall, etc.

Block 14: For Dental Use Only

a. Enter the appropriate tooth number and surface area.

Block 15:

a. **Signature of requesting provider:** This form must be signed by the provider requesting the services to be prior authorized.
b. **Date:** Enter the date the form was signed. The date of the signature will be considered the effective date unless physician authorizes date in block 13 as DOS.

Quick Tips:

Please be mindful of the following when completing a 719A form:

- Copies of the 719A form are acceptable for original prior authorization requests.
- Initial and date any corrections made on the form.
- All 719A forms must be typed or printed legibly.
- Use miscellaneous codes **ONLY** when a more precise and appropriate HCPCS code is not available.
- When using a miscellaneous code, include the manufacturer's quote, invoice or paid receipt with the 719A form, in addition to the required documentation.
- Prior authorization (PA) does not guarantee payment. A PA only authorizes that services and/or equipment may be provided.
- Payment for services and supplies is rendered in accordance to the fee schedule.
- Do not submit claims for a procedure requiring prior authorization without first obtaining the PA number. If you submit a claim for a procedure code that requires a PA, your claims will deny. Please consult the fee schedule to verify if the procedure code requires prior authorization. Once the PA request has been approved, you will receive a Prior Authorization letter containing the prior authorization number to enter on your claim.
- If the 719A form was returned, you may resubmit the form after making the necessary corrections. Be sure that you initialed and dated any modifications made on the form. Resubmissions must include all required documentation and the letter received identifying the reason for the return.
- Submit new 719A forms only when requested.

Sample 719A Form

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

PRIOR AUTHORIZATION REQUEST/APPROVAL

BILLING PROVIDER: ABC MEDICAL SUPPL
PROVIDER NUMBER: 023435100

558152

1 PATIENT

A. RECIPIENT D.C. I.D. NUMBER: 7001555
B. NAME (LAST, FIRST, M.I.) PRINT: Doe, Jane
C. ADDRESS: 825 North Capital Street NE
D. TELEPHONE NUMBER: 202 -877-9052
E. DATE OF BIRTH: 12/21/68
F. SEX: ☐ M ☐ F

2 REQUESTING PROVIDER

A. PROVIDER NUMBER: 034887900
B. NAME (LAST, FIRST, M.I.) PRINT: Brody, Frederick, M.D.
C. ADDRESS: 2150 Penn. Avenue NW
D. CITY: Washington, DC 20037 STATE ZIP
E. TELEPHONE NUMBER: 202 441-2587

3 OTHER HEALTH INSURANCE COVERAGE

ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY. IF NONE PLEASE INDICATE.

N/A

4 REQUESTED SERVICE

SURGERY ☐
MEDICAL ☐
DENTAL ☐
MEDICAL SUPPLIES OR EQUIPMENT ☐
TRANSPORTATION ☐
EYEWEAR ☐
OTHER ☐

5 PATIENT LOCATION

HOME ☐
ICF/MR ☐
NURSING HOME ☐
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 "/", 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		PRIMARY TEETH	AA	BB	CC	DD	EE	FF	GG	HH	II	JJ	PRIMARY TEETH		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)

719A Submission

Service	Who to contact for Prior Authorizations	Delmarva	DHCF/ Medicaid	Other
Botox	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-279-2011	X		
Cosmetic, Plastic, reconstructive surgery (limited coverage)	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-279-2011	X		
Dental Services	Delmarva Foundation Dental Coordinator: 202-496-6549 Fax number: 1-866-906-3293	X		
Durable Medical Equipment	Delmarva Foundation DME Coordinator: 1-800-638-6415 Fax number: 1-866-906-3292	X		
Hearing Aids and Artificial Larynxes (for Adults)	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-360-3291	X		
Home Infusion	Department of Health Care Finance (DHCF) Office of Pharmacy Management: 202-442-9078		X	
Home and Community Based Waiver Services for Persons with Intellectual Disabilities / Developmental Disabilities	DC Department on Disability Services Developmental Disabilities Administration Medicaid Waiver Office 202-730-1558 Fax number: 202-730-1804			X
Home and Community Based Waiver Services for Elderly Persons with Disabilities—CASENET PROVIDERS	Delmarva Foundation Long Term Care Unit: 410-763-6288	X		
Home and Community Based Waiver Services for Elderly Persons with Disabilities—NON-CASENET PROVIDERS	DHCF Office of Chronic & Long-Term Care 202-442-9225		X	
Home Health Services (non waiver)	DHCF Office of Chronic & Long-Term Care 202-442-5912		X	
Injections Administered in a Physician's office ("J codes")	DHCF Office of Pharmacy Management:		X	

Service	Who to contact for Prior Authorizations	Delmarva	DHCF/ Medicaid	Other
	202-442-9078			
Inpatient Hospital Admissions	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-279-2424	X		
Medications dispensed by a pharmacy	ACS Help Desk 1-800-273-4962			X
Nutritional Supplements (tube feedings) for in-home care	DHCF Office of Pharmacy Management: 202-442-9078		X	
Orthotics and Prosthetics	Delmarva Foundation DME Coordinator: 1-800-638-6415 Fax number: 1-866-906-3292	X		
Optical Services	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-360-3291	X		
Organs Transplants (when covered; e.g., heart, kidney, liver, allogeneic bone marrow	DHCF / Medicaid: Medical Director 202-442-9077 Fax number: 202-535-1216		X	
Outpatient Procedures /Surgeries	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax: 1-866-279-2011	X		
Pain Management Procedures (Inpatient)	Delmarva Foundation Prior Authorization Unit: Fax number: 1-866-279-2011	X		
Pediatric Specialty Hospital Admissions (i.e., Cumberland and Kennedy Krieger Hospitals)	DHCF/ Medicaid: Medical Director 202-442-9077 Fax number: 202-535-1216	X		
Personal Care Aide Services (non waiver)	DHCF Office of Chronic & Long-Term Care 202-442-5912		X	
Pet Scans	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-279-2011	X		
Sleep Studies	Delmarva Foundation Prior Authorization Unit: 202-496-6541 Fax number: 1-866-279-2011	X		
Surgical procedures (Some types require prior authorization, including: gastric bypass surgery,	Delmarva Foundation Prior Authorization Unit: 202-496-6541	X		

Service	Who to contact for Prior Authorizations	Delmarva	DHCF/ Medicaid	Other
mammoplasty	Fax number: 1-866-279-2011			

All other 719A form requests and required documentation should be sent to:

Office of Quality Management
825 North Capitol St., NE
Suite 5135
Washington, DC 20002

Failure to send the form and all required documentation to the correct office will delay processing of the request.