NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

273 AT FFS
09/2021

REQUEST FOR SERVICE AUTHORIZATION
FOR SERVICES NOT ADDRESSED ON OTHER FORMS
(Fee-for-Service (FFS) Program Only – Not for Managed Care program use)
Instructions for filling out this form are attached.

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****

RECIPIENT INFORMATION **TODAY'S DATE:**

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS CODES: _____

ALTERNATE INSURANCE PLAN NAME:

PROVIDER INFORMATION

CONTACT PERSON: _____ EMAIL:_____

TELEPHONE #: _____ FAX #: _____

PERFORMING PROVIDER NAME: MEDICAID PROVIDER ID #:

ORDER INFORMATION

Requested Procedure	CPT Code	Number of units	Start of Service	End of Service	State use only

PHYSICIAN'S ORDER AND LETTER OF MEDICAL NECESSITY

Pursuant to He-W 520.02(b)(2) Request and obtain prior authorization from the department before providing any Medicaid covered services requiring prior authorization.

Clinical information supporting the medical necessity for the request, including, but not limited to, the medical care plan, relevant diagnostic tests, and progress notes must be attached.

For the items listed above: (please check and include all.)

- ☐ I certify that I have attached a Physician's order and a LMN pursuant to He-W 571.05(d).
- ☐ I certify that products/procedure listed will be provided to the recipient.

_____

Signature *Date*

_____

Printed Name *Title*

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

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PLEASE FORWARD THIS INFORMATION TO ATTENTION – MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 271-8194

INSTRUCTIONS FOR SERVICE AUTHORIZATION: FORM 273AT FFS REQUEST FOR SERVICE AUTHORIZATION NOT ADDRESSED ON OTHER FORMS

We suggest you not use this form for service authorization requests unless you feel your service is not covered by one of the other forms. Each form is specific to a specialty and requires different information than other forms. By using this generic form, you may not be including all the information needed for the department to make a determination. This will delay the authorization process.

This form must be filled out pursuant to He-W 520.02(b)(2) Request and obtain prior authorization from the department before providing any Medicaid covered services requiring prior authorization.

Please note that before this form is filled out, it is your responsibility to check eligibility of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly.

The next section is what you are requesting. Fill in a description of the procedure, the Procedure Code the number of units, and the start date of service and end date of service.

For your convenience, the section following is the legal information with references to the Medicaid rule. The signature should be that of the person completing the form.

To submit documents request a secured email link, by emailing ServiceAuthorizationFFS@dhhs.nh.gov. In the subject line write Requesting Approval for: then choose DME, Incontinence, Therapy etc. You will receive a secured email thread. Alternatively you can use your own process for securing Protected Health Information in documents sent by email. Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Return all documentation and the Service Authorization Request form to SerivceAuthorizationFFS@dhhs.nh.gov or fax to: 603-271-8194.

If the information sent is incomplete, you will receive a request for more information. This is not a denial. Send in the information as above for the request to be reconsidered.

If all information is complete and criteria is met, you will receive a form from the state with the approval information. Once the Request for Service Authorization has been approved by the State it is sent to the Fiscal Agent, Conduent, to create the authorization. Conduent has three business days to create and mail the authorization to the performing provider. If you have questions, please call Conduent at 1-866-291-1674.