

**INSTRUCTIONS**  
**DHS 1144**  
**REQUEST FOR MEDICAL AUTHORIZATION**

- I. Purpose:** The DHS 1144 Form is used to obtain medical authorization of medical services/equipment/items. It should not be used for obtaining any of the following services/equipment/items: (1) Drugs; (2) EPSDT medically fragile case management, skilled nursing and/or personal care; and (3) Incontinence supplies.
- II.** Prior Authorization (PA) No.: On receipt of this 1144 Form, ACS will assign an authorization number. **DO NOT WRITE ANTHING HERE.**
- III.** Each 1144 has 5 lines for requestors to describe and code the services/items being requested. Thus, if more than 5 lines are needed to identify the services/items requested, the requestor **MUST** indicate the page number of each sheet and the total number of sheets per request.
- IV.** Check "Urgent" if applicable. Requests are considered **URGENT** only if the patient has an urgent need for the service/equipment/item. The "Urgent" box **MUST NEVER** be checked if the physician/supplier is late in submitting the request, has submitted the request before, but has not received a response, or wants the request authorized quickly. Certain equipment for discharge from the hospital are not considered urgent because they have a 30 day conditional approval. (See the Medicaid Provider Manual) Check "Extension Request" if an initial request for the same service/item was requested and the current request is for continuation of the service/item. Check "New Request" if this is the first time an authorization is requested for the service/item.
- V.** Check only one of the 12 blocks that apply to the type of service being requested. Each type of service must be requested on a separate 1144 Form.
- VI. General Instructions:** Type or print legibly. ***An incomplete form will be returned to the provider and delay the authorization process.***
- A. Recipient Information:** *This section is to be completed by the provider.*
1. Enter Medicaid I.D. Number, Patient's Name, Gender, and Date of Birth (mm/dd/yy).
  2. Check the appropriate box "Yes" or "No" about Medicare coverage and/or Medicare Home Health Benefits.
  3. Check type of Present Address, and provide Patient's Mailing Address. If "Other" is checked, provide the name--example: Jane Doe, Care Home.
- B. Physician Section:** *This section is to be completed by the physician.*
1. Describe the service(s) being requested, indicate the appropriate CPT/HCPCS code and the quantity requested.
  2. Provide the justification for the medical need of the service/item for the specific patient. Indicate "Yes" or "No" if you are attaching additional justification or documents justifying the medical need to the 1144 Form.
  3. Sign the form and provide a date. Your signature certifies that the patient is under your care and that the service(s) requested are medically necessary for the patient. Your signature on this 1144 Form carries the same medical/legal responsibility as that on a prescription.

4. Print legibly or stamp Physician/Provider Name and Provider Number. Provide Contact Name (if different from physician), Telephone Number, and Fax Number where the Medicaid Consultant can contact the Provider if additional information is needed to process the request.

**C. Supplier Section:** *This section is to be completed by the Supplier.*

1. Indicate the purchase price (your charge for the equipment/supply/item). Circle rent or repair as appropriate (Purchase price, rent/repair should be left blank on requests for professional services). Indicate the period requested.
2. Print legibly or stamp Supplier Name and Supplier Number.
3. The supplier may make comments in the section "Physician/Supplier Comments."
4. If applicable--indicate the serial number. This is required for FINAL approval of wheelchairs, hearing aids, and hospital beds. Please supply it if you have it for other kinds of equipment. Indicate "Yes" or "No" for MSRP attached. (This serial number and the MSRP attachment should be left blank on requests for professional services).
5. The Supplier or its authorized representative must sign and date the form. The supplier signature certifies that the items and quantities requested were prescribed by the physician indicated on the form and will be provided by the supplier.
6. Print legibly or stamp the supplier/company name (do not enter the name of the person signing the form if it is not the same as the supplier/company name that corresponds to the Supplier Provider Number) and Supplier Provider Number.
7. Print Contact Name, Telephone Number, and Fax Number where the Medicaid Consultant can contact the Supplier if additional information is needed to process the request. Enter the Quantity/Month for the items being requested.

**D. To be completed by Medicaid:** *This section is to be completed by the Medicaid Consultant. It will only be returned to the physician and supplier if the request is urgent or if the request is complex.*

1. Consultant will indicate the modifier (if appropriate) for each code line and the quantity approved.
2. Consultant will assign a Code for each item; such as: A – Approved, P – Pend, or D – Denied, R – Revoked.
3. Consultant will enter Period Approved.
4. Consultant will write comment (s), as needed.