

REQUEST FOR MEDICAL AUTHORIZATION OF INCONTINENCE SUPPLIES

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant. Do not submit for patients in SNF/ICF/ICF-MR facility as payment is included in the facility per diem.

PLEASE PRINT INFORMATION CLEARLY

Medicaid Identification Number:	Patient's Name (Last, First, M.I.)	Date of Birth:	Gender: [] F [] M
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Present Address: [] Own Home/Family Home [] Care Home (CH) _____ [] Foster Home (FH) _____
 _____ (Name of CH) _____ (Name of FH)
 [] Medicaid Waiver Program [] Other _____
Patient's Mailing Address:
 (Street, City and Zip Code)

TO BE COMPLETED BY PHYSICIAN. FAILURE TO COMPLETE NUMBERS 1 – 5 WILL RESULT IN RETURN OF REQUEST. SUBMIT JUSTIFICATION FROM PHYSICIAN FOR QUANTITIES EXCEEDING 200 DIAPERS, 50 UNDERPADS AND 100 GLOVES.

1) Incontinence is secondary to:
 [List specific diagnosis(es)]

2) Recipient requires diapers: [] Yes [] No If Yes, number used per month _____.	3) Recipient requires underpads: [] Yes [] No If Yes, number used per month _____.	4) Caregiver requires gloves: [] Yes [] No If Yes, number used per month _____. Note: For Non-Latex Gloves submit medical justification.	5) Required justification attached: [] Yes [] No If Yes, number of pages _____.
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I certify that the above named patient is under my care and requires the number of incontinence supplies I have prescribed. Physician's Signature: _____ Date: _____

Physician/Provider Name: _____ Provider Number: _____

Contact Name: _____ Telephone Number: _____ Fax Number: _____
 (If different from Physician)

To be completed by Supplier.

Supplier Name: _____ Supplier Number: _____

Contact Name: _____ Telephone Number: _____ Fax Number: _____
 (If different from Supplier)

Supplier's Signature: _____ Date: _____

To be completed by Supplier.				To be Completed by Medicaid (A=Approved P=Pended D=Denied)					
Code	Item	Qty./Mo.	Period Requested	Qty./Mo.	Auth. #1	Auth. #2	Period Approved	Comments	
			From: To:				From: To:		
A4521	Diapers, Adult Small/All Children's								
A4522	Diapers, Adult Medium/Large								
A4524	Diapers, Adult Extra Large								
A4554	Underpads, Large								
A4927	Gloves, Latex (each)								
A4927	Gloves, Non-Latex (each)								

To be completed by Medicaid.

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<p>#1 Consultant/Reviewer Initial: Date:</p> <p>#2 Consultant/Reviewer Initial: Date:</p>	<p>Additional Comments:</p>
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