INSTRUCTIONS

DHS 1144A

REQUEST FOR MEDICAL AUTHORIZATION OF INCONTINENCE SUPPLIES

I. **Purpose:** The DHS 1144A form is used to obtain medical authorization of incontinence supplies, which are necessary for the care of Medicaid patients with bowel and bladder incontinence.

II. **General Instructions: Type or print legibly.** ***An incomplete form will be returned to the Physician/Provider.***

A. **Patient Information:** *This section is to be completed by the Physician/Provider.*

1. Enter Medicaid Identification Number, Patient's Name, Date of Birth (mm/dd/yy), and Gender.

2. Check type of Present Address, and provide Patient's Mailing Address.

B. **Physician/Provider Information**: *This section is to be completed by the Physician/Provider.*

1. List specific diagnosis(es) causing the incontinence (e.g., neurogenic bowel and bladder secondary to spinal cord injury/stroke/multiple sclerosis; severe dementia/mental retardation, etc.).

2. Check Yes or No in the appropriate box to indicate whether the patient requires diapers. If Yes, enter the number of diapers used per month.

3. Check Yes or No in the appropriate box to indicate whether the patient requires underpads. If Yes, enter the number of underpads used per month.

4. Check Yes or No in the appropriate box to indicate whether caregiver requires gloves. If Yes, enter the number of gloves (**each**, not pairs) used per month.

5. Check Yes or No in the appropriate box to indicate whether additional justification is attached.

6. The Physician/Provider who is requesting incontinence supplies and certifying that the patient is under his/her care must sign and date the form.

7. Print legibly or stamp Physician/Provider Name and Provider Number.

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

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

1. Print legibly or stamp Supplier Name and Supplier Number.

2. Provide Contact Name (if different from supplier), Telephone Number, and Fax Number where the Medicaid Consultant can contact the Supplier if additional information is needed to process the request.

3. The Supplier or its authorized representative must sign and date the form.

4. Enter the Quantity/Month for the items being requested.

5. Enter Period Requested for supplies. If the supply was provided prior to approval, indicate the date provided, in the Comments section. Provide justification for the late submission of the 1144A.

D. **Medicaid Section:** *This section is to be completed by the Medicaid Consultant.*

1. Consultant will indicate the Quantity/Month for incontinent supplies that are approved.

2. Consultant will assign a Code for each item; such as: A – Approved, P – Pend, or D – Denied.

3. Consultant will enter Period Approved for supplies.

4. Consultant will write comment(s), as needed.

5. Consultant will provide Initial and Date for 1st review; and 2nd review, if applicable.

6. Additional Comments Section may be used for additional remarks.

E. On receipt of this 1144A form, the Affiliated Computer Services (ACS), the Medicaid Fiscal Agent, will assign a prior authorization (PA) number.