



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

272 DIA
SR 10XX
01/10

INCONTINENCE PRODUCTS
PRIOR AUTHORIZATION REQUEST FORM

PLEASE PRINT OR TYPE ALL INFORMATION

RECIPIENT NAME: _____ RECIPIENT DATE OF BIRTH: ____/____/_____
RECIPIENT MEDICAID ID: _____

PROVIDER INFORMATION

DATE OF REQUEST: ____/____/_____
PROVIDER NAME: _____ CONTACT PERSON #: _____
ADDRESS: _____ NH MEDICAID PROVIDER #: _____
TELEPHONE #: _____ CITY/STATE/ZIP: _____
FAX #: _____
ICD-9 CODE(S): _____ ORDERING PHYSICIAN: _____
WRITTEN DIAGNOSIS: _____

INCONTINENCE PRODUCT(S) REQUESTED

HCPC Code	Modifier	Description	Units Requested	Units Exceeding Limits (if applicable)
Diapers				
T4521				
T4522				
T4523				
T4524				
T4525				
T4526				
T4527				
T4528				
T4533				
T4534				
T4543				
Liners				
T4535				
Underpads				
T4541				

CERTIFICATION OF MEDICAL NECESSITY

Pursuant to He-W 571.06, to document the medical necessity for the item/service requested above, the **written** diagnosis and supporting clinical information **must be attached and included** with your request, and be **signed** by a PCP, treating physician or APRN. Pursuant to He-W 571.06 for adults, or He-W 546.06 for EPSDT recipients, the same documentation of medical necessity above is required for requests that exceed established quantity limits.

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

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

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