

AUTHORIZATION REQUEST

Purchase of Medical Care Services
DHHS – Controller's Office

Read Instructions on Back

1. Last Name			First Name			MI			11. Program			12. Authorization Number					
2. Patient SS #									13. POMCS Case Number								
3. Date of Birth		Month	Day	Year		4. Sex <input type="checkbox"/> 1. Male			<input type="checkbox"/> 2. Female								
5. Race <input type="checkbox"/> 1. White			<input type="checkbox"/> 2. Black			<input type="checkbox"/> 3. American Indian			<input type="checkbox"/> 4. Asian			14. Name and Address of Hospital or Provider of Requested Service					
<input type="checkbox"/> 5. Native Hawaiian/Other Pacific Islander			<input type="checkbox"/> 6. Unknown			Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
6. County of Residence									Phone #:								
7. Address			Street or RFD						15. Requested dates of service								
8. City			State			Zip Code			16. Service is authorized for the following dates:								
9. Telephone #			Home			Work											
10. Name of Parent or Guardian			Last			First			Middle								
17. Diagnostic Code/Diagnosis:			Primary			Secondary											
18. Insurance or Third Party <small>(Attach copies of all Insurance Cards)</small>			Policy #			Policyholder			Claims Address								
Does this policy cover this service? <input type="checkbox"/> Yes <input type="checkbox"/> No												Is this an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No			If an HMO, documentation is required. See reverse.		
19. COMPLETE FOR CANCER TREATMENT REQUESTS						20. COMPLETE FOR ALL HIV REQUESTS											
A. Estimated five-year survival rate: _____%						A. CD ₄ Count _____											
B. Recurrent disease: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach statement about history.						B. Viral Load _____											
C. Stage of disease or TNM classification _____																	
D. For Cervical Intraepithelial Neoplasia, check appropriate box: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe																	
21. CHECK SERVICE REQUESTED All programs do not cover all types of service.																	
A. <input type="checkbox"/> Inpatient Admission for _____ days			G. <input type="checkbox"/> Appliances/supplies. Give estimated cost in #22														
B. <input type="checkbox"/> Inpatient Extension for _____ days			H. <input type="checkbox"/> Formula ____ oral ____ enteral														
C. <input type="checkbox"/> Outpt. (Hosp., Dial, FASC) for _____ visits			I. <input type="checkbox"/> Home Nursing Care Tot. # _____ Freq. _____														
D. <input type="checkbox"/> Physician's Office for _____ visits			J. <input type="checkbox"/> Residential Care for _____ days														
E. <input type="checkbox"/> Therapy (PT, OT, SP) Tot. # _____ Freq. _____ Sess. Lgth. _____			K. <input type="checkbox"/> Nutri. Counseling Tot. # _____ Freq. _____														
F. <input type="checkbox"/> Drugs related to program covered condition																	
22. Describe service requested. Give estimated cost for each appliance.																	
23. Ship equipment to:																	
24. Enter names and addresses of providers to whom a copy of approved Authorization should be sent for billing purposes. Do not include those listed in blocks 14 and 27.																	
25A. Type or print physician's name						27. Requesting Office											
						Contact:											
25B. Physician's Signature						Address:											
26. Other Applicable Signature																	
						Phone #:											
						Date:											
						Month						Day					
						Year											

INSTRUCTIONS

PURPOSE

This form is used to request authorization for reimbursement from the following programs: Adult Cystic Fibrosis, Assistive Technology, Cancer Control, Children's Special Health Services, HIV Medications, Kidney and Sickle Cell. As of April 1999, the Migrant Health Program no longer requires Authorization Requests.

To qualify for payment, an applicant must be eligible for the program and an Authorization Request must be received within one year after the date of service. Processing time is reduced when this form is legible and complete. If requested, additional information must be received within one year after the date of service or within 30 days of notification, whichever is later. Incomplete forms will be returned.

Requests under Assistive Technology for Infants and Toddlers must be submitted by the third birthday. **Authorization Requests should be submitted without documentation if necessary to meet deadlines.** Requests will not be processed until all information is received.

INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM

9., 14., 27. Include area code with phone number.

11. Specify program applied for.

12., 16. For POMCS use only. Do not complete these items.

17. Provide ICD-9 code if available. **Diagnosis should correspond to requested service.**

18. Provide complete insurance information. Attach copies of all insurance cards. Submit HMO denial or statement of benefits **if** HMO does not cover or partially covers requested service.

19. For cancer treatment only. Do not complete for diagnostic requests.

20. For HIV Program only. Provide most recent values.

21. **All Programs Do Not Cover All Types of Service.** Refer to individual program guidelines regarding coverage limitations.

ALL PROGRAMS

- Use separate forms for different types of service
- Use separate forms for each inpatient admission
- Use separate forms for each DME provider

CANCER CONTROL PROGRAM

- Use separate forms for diagnostic and treatment requests
- Designate follow up visits

22. Medical documentation is sometimes required. Refer to individual program guidelines regarding specific requirements.

23. Equipment is shipped to patient's home unless alternate address is listed here.

24. Include CAP case manager's name, address and signature if patient covered by CAP Medicaid.

25. Reserved for physician's name and signature. Cancer Control Program requires signature of attending physician. Children's Special Health Services requires original signature of program rostered physician. HIV Program allows signature of PA or Nurse Practitioner.

26. Enter signature of clinician, PA or practitioner specified by program.

MAIL REQUESTS TO: Purchase of Medical Care Services
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, NC 27699-1904

Faxed Authorization Requests are not given priority. Requesting offices should contact POMCS regarding the need to expedite a request.

BILLING INSTRUCTIONS

After a service has been authorized and provided, claims should be submitted to the POMCS Claims Processing Unit, DHHS-Office of the Controller, 1904 Mail Service Center, Raleigh, NC 27699-1904. All third party payors must be billed. Providers must wait for payment or denial or wait up to six months, whichever comes first, before billing a POMCS program. **All claims must be received within one year after the date of service in order to be paid.** Additional billing information is available upon request.

HOW TO ORDER THIS FORM

You may obtain this form by mailing a request to the above address or faxing your order to 919-715-3848. Call 919-855-3672 to request a POMCS Order Form (DHHS 3202).

WEBSITE: <http://www.dhhs.state.nc.us/control/pomcs/pomcs.htm>