



# NC DMA Request for Prior Approval CMN/PA



## Recipient Information

DMA372-131

1. Recipient Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
 3. Recipient ID # \_\_\_\_\_ 4. Recipient Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

## Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

## Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid:  Health Choice:

## Provider Information

7. Requesting Provider #: \_\_\_\_\_ NPI:  Atypical:  8. Taxonomy: \_\_\_\_\_  
 9. Address: \_\_\_\_\_ 10. Nine Digit Zip Code: \_\_\_\_\_  
 11. Billing Provider # (if different from requesting): \_\_\_\_\_ NPI:  Atypical:  12. Taxonomy: \_\_\_\_\_  
 13. Address: \_\_\_\_\_ 14. Nine Digit Zip Code: \_\_\_\_\_  
 15. Rendering Provider # (if different from billing): \_\_\_\_\_ NPI:  Atypical:  16. Taxonomy: \_\_\_\_\_  
 17. Address: \_\_\_\_\_ 18. Nine Digit Zip Code: \_\_\_\_\_  
 Requester Contact Information Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

## Medical and Functional Status

19. **Condition:** Stable:  Unstable:  Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 20. **Prognosis:** Terminal:  Poor:  Guarded:  Fair:  Good:  Excellent:   
 21. **Patient:** Requires positioning not feasible in ordinary bed:  Unattended for long periods of time:  Lives alone:   
 22. **Equipment:** Necessary to retard deterioration of condition:  Necessary for function:  Specify \_\_\_\_\_ Length of need: \_\_\_\_\_  
 23. **Mental:** Oriented:  Forgetful:  Disoriented:  Agitated:  Comatose:  Depressed:  Lethargic:  Infant:  Other: \_\_\_\_\_  
 24. **Neurological:** Muscle Tone: Normal:  Increased:  Decreased:  Fluctuating:   
 Sensation: Normal:  Abnormal:  Specify: \_\_\_\_\_  
 25. **Respiratory:** Normal:  SOB on minimal exertion:  Tracheostomy:   
 O2:  Flow Rate: \_\_\_\_\_ Frequency: \_\_\_\_\_ Test Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 26. **Skin:** Normal:  Other:  Specify: \_\_\_\_\_ Decubiti:  Specify: \_\_\_\_\_  
 27. **Ambulatory:** Complete bedrest:  Up as tolerated:   
 Transfers bed-chair (indep):  Transfers bed-chair (w/assistance):  Confined to wheelchair?  Hours per day: \_\_\_\_\_  
 Walks unassisted:  Walks with assistive device:  Specify: \_\_\_\_\_ Max distance walked: \_\_\_\_\_  
 28. Can place of residence physically accommodate equipment being requested?  Yes  No  
 29. Patient's status will be monitored by physician while assistance is provided?  Yes  No  
 30. Medical Necessity of equipment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Requesting Provider's Signature \_\_\_\_\_

Fax this form to CSC at: (855) 710-1964

Date \_\_\_\_\_

Physician, PA, Nurse Practitioner Signature \_\_\_\_\_

Date \_\_\_\_\_

Instructions for completing this form can be found at <http://www.NCTracks.com/PAformhelp>