

Completion Instructions for MSA-1653-B

Special Services Prior Approval - Request/Authorization

The MSA-1653-B must be used by Medicaid enrolled Medical Suppliers, DME Providers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists, and Cochlear Manufacturers. MDCH requests that the MSA-1653-B be typewritten to facilitate processing. Fill-in enabled copies of this form can be downloaded from the MDCH website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. The form is generally self-explanatory. Completion of boxes 2 through 27 is mandatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDCH website.

Box 1	MDCH Use Only
Box 12	Check Yes if beneficiary is in a Nursing Care Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Care Facility name, address and phone number.
Box 19	Enter a complete description of the item requested, including manufacturer, model, style, etc.
Box 20	Enter the HCPCS Procedure Code
Box 21	Enter the applicable HCPCS Modifier
Box 24	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). Othotic and Prosthetic Providers must submit the prescription/CMN with this form.
Box 25	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested, other insurance coverage for services requested, etc.

Form Submission

PA request forms for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDCH - Medical Services Administration
 Program Review Division
 P.O. Box 30170
 Lansing, Michigan 48909

Fax Number: **(517) 335-0075**

To check the status of a PA request, contact the MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act
 COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Michigan Department of Community Health
SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)		3. NPI NUMBER		4. PHONE NUMBER	
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER	
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)					
12. DOES BENEFICIARY RESIDE IN A NURSING CARE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER.					
13. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)		14. NPI NUMBER		15. PHONE NUMBER	
16. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				17. FAX NUMBER	
18. LINE NO.	19. DESCRIPTION OF SERVICE (INCLUDE BRAND NAME AND MODEL NUMBER WHERE APPLICABLE)	20. PROCEDURE CODE	21. MODIFIER	22. QUANTITY	23. CHARGE
01					
02					
03					
04					
05					
06					
07					
24. ICD-9-CM DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.			25. REMARKS AND/ OR DOCUMENTATION OF MEDICAL NECESSITY		
26. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR					
27. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAW.					
PROVIDER SIGNATURE				DATE	
MDCH USE ONLY					
28. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>			29. CONSULTANT REMARKS		
CONSULTANT SIGNATURE				DATE	