

Michigan Department of Community Health
Special Services Prior Approval - Request/Authorization
Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled Medical Suppliers, DME Providers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers. Note: Requests for new or replacement wheelchairs require completion of only boxes 2-18 and 28 submitted with a completed "Mobility and Seating Evaluation and Justification" form (MSA-1656).

MDCH requests that the MSA-1653-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDCH website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. The form is generally self-explanatory. 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. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDCH Use Only
Box 12	Check Yes if beneficiary is in a Nursing Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Facility name, address and phone number.
Box 18	Complete this box ONLY for wheelchair requests. <ul style="list-style-type: none"> • For repairs or parts, complete MSA-1653-B. (Do not include MSA-1656.) • For new or replacement requests, stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter the HCPCS Procedure Code.
Box 22	Enter the applicable HCPCS Modifier.
Box 25	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 26	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 28	Must be completed for all requests.

Form Submission

PA request forms and required documentation 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 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. WHEELCHAIR REQUESTS ONLY (CHECK APPROPRIATE BOXES)

A. IF THIS FORM IS FOR REPAIR, PARTS, ADDITIONS OR REVISIONS COMPLETE ENTIRE FORM.

B. ARE REPAIR OR PARTS TO THE WHEELCHAIR ASSOCIATED WITH THE BENEFICIARY'S FUNCTIONAL STATUS: YES NO

C. IF THIS FORM IS FOR
 NEW WHEELCHAIR OR
 REPLACEMENT WHEELCHAIR, **PROCEED TO SECTION 28, SIGN, AND SUBMIT WITH A COMPLETED FORM MSA-1656.**

19. LINE NO.	20. DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER)	21. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE
01					
02					
03					
04					
05					
06					
07					

25. ICD-9-CM DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	26. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.
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27. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

28. 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/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE _____ DATE _____

MDCH USE ONLY

29. 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"/>	30. CONSULTANT REMARKS
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CONSULTANT SIGNATURE _____ DATE _____