Michigan Department of Health and Human Services

Complex Seating and Mobility Device Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-D must be used by Medicaid enrolled DME Providers. Note: Requests for new complex seating or mobility devices submit with a completed Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices" form (MSA-1656).

MDHHS requests that the MSA-1653-D be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & 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 MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 11	Beneficiary address. If beneficiary resides in Nursing Facility include the Nursing Facility name, address and phone number.
Box 17	Complete this box ONLY for wheelchair requests. • For repairs or parts, complete MSA-1653-D. (Do not include MSA-1656.) • For new or replacement (due to a change in beneficiary basic medical functional status requests), stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter brand name, model catalog or part number. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter a complete description of the item requested.
Box 22	Enter the HCPCS Procedure Code.
Box 23	Enter the applicable HCPCS Modifier.
Box 28	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 29	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 31	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:

MDHHS – Health Services
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 MDHHS – Health Services, 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 Health and Human Services is an equal opportunity employer, services and programs provider.

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1. PRIOR AUTHORIZATION NUMBER (MDHHS 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 ☐ M ☐ F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP). IF RESIDES IN NURSING FACILITY INDICATE NAME OF FACILITY, ADDRESS AND PHONE NUMBER.			
12. NAME OF DESIGNATED CONTACT PERSON (E.G., BENEFICIARY, PARENT, GUARDIAN, ETC.)			13. PHONE NUMBER
14. OTHER INSURANCE NAME	15. POLICY NUMBER		16. FAX NUMBER
17. AUTHORIZATION TYPE: ☐ **NEW WHEELCHAIR/REPLACEMENT** ☐ **REPAIR** ☐ **RENTAL ONLY**			18 **MSA-1656 SUBMITTED ON**

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21.DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE? YES	26. NO	27. DATE LAST REPLACED (MM/DD/YYYY)
01							☐	☐	
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FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

28. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	29. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

30. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

31. DME 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.

DME'S SIGNATURE DATE

ADDITIONAL DME'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION: ☐ APPROVED ☐ DENIED ☐ RETURN ☐ NO ACTION ☐ APPROVED AS AMENDED

33. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE

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Additional Page (Use only if requesting additional mobility items)

Beneficiary Name: _____ Mihealth Number: _____

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21. DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE?		27. DATE LAST REPLACED
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