Michigan Department of Health and Human Services

Practitioner Special Services Prior Approval - Request/Authorization

Completion Instructions

The MSA-6544-B must be used by Medicaid enrolled providers to request provider services that require prior authorization (PA) (e.g. out-of-state care).

MDHHS requests that the MSA-6544-B 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](http://www.michigan.gov/medicaidproviders) >> Policy, Letters & Forms. For information on required procedure codes, 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](http://www.michigan.gov/medicaidproviders) >> Billing and Reimbursement >> Provider Specific Information.
* CHAMPS Medicaid Code and Rate Reference Tool available in CHAMPS via the External Links menu.

Completion of this form is as follows:

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| --- | --- |
| **Box 1** | MDHHS Use Only |
| **Box 22** | Indicate whether this is the first request for services or if this is a renewal request for ongoing services. |
| **Box 24** | Enter a complete description of the services, procedures, etc. requested. |
| **Box 25** | Enter the HCPCS Procedure Code. |
| **Box 26** | Enter the applicable HCPCS Modifier. |
| **Box 27** | Enter the quantity of the services requested. If an injectable drug is requested, indicate the number of billing units requested. |
| **Box 28** | Enter the dates for which the requested procedure or service will take place. Include the dates of travel, if travel assistance will be needed. |
| **Box 29** | Enter the beneficiary’s primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). |
| **Box 30** | 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** | Check each box that corresponds to documentation included in the request. No request should leave all boxes unchecked. |
| **Box 32** | 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**

The status of a PA request may be reviewed in CHAMPS. For additional questions, contact the MDHHS – Health Services, Program Review Division via telephone at **1-800-622-0276.**

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| Michigan Department of Health and Human Services  **PRACTITIONER SPECIAL SERVICES**  **PRIOR APPROVAL – REQUEST/AUTHORIZATION** | | | | | | 1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY) | | | | | |
| **The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.** | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | 2. REASON FOR PA REQUEST: | | | | | Out of state care | clinical procedure | office administered drug or biological | Surgery | | other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | | | | | | | | | | | | |
| 3. PROVIDER’S NAME (LAST, FIRST, MIDDLE INITIAL) | | | | 4. NPI NUMBER | | | | | | 5. Phone Number | |
| 6. PROVIDER’S ADDRESS (NUMBER, STREET, ste., CITY, STATE, ZIP) | | | | | | | | | | 7. FAX NUMBER | |
| 8. Beneficiary's NAME (LAST, FIRST, MIDDLE INITIAL) | | | | 9. SEX  **M**  **F** | | | | 10. BIRTH DATE | | 11. MIHEALTH CARD NUMBER | |
| 12. beneficiary's ADDRESS (NUMBER, STREET, apt./lot number, CITY, STATE, ZIP) | | | | | | | | | | | |
| 13. Hospital/ Facility Name | | | | | 14. Hospital/ Facility NPI | | | | | | |
| 15. REFERRING/ordering PHYSICIAN’S NAME (LAST, FIRST, MIDDLE INITIAL) | | | | 16. NPI NUMBER | | | | | 17. PHONE NUMBER | | |
| 18. REFERRING/ordering PHYSICIAN’S ADDRESS (NUMBER, STREET, ste., CITY, STATE, ZIP) | | | | | | | | | 19. FAX NUMBER | | |
| 20. Contact Name | | | | | | | | | 21. Contact phone nUMBER | | |
| 22.  Initial Request  Renewal Request | | | | | | | | | | | |
| 23.  LINE  NO. | 24.  DESCRIPTION OF SERVICE | 25.  PROCEDURE CODE | | | | | 26.  MODIFIER | | 27.  Quantity | | 28.  anticipated date(s) of service | |
| 01 |  |  | | | | |  | |  | |  | |
| 02 |  |  | | | | |  | |  | |  | |
| 03 |  |  | | | | |  | |  | |  | |
| 04 |  |  | | | | |  | |  | |  | |
| 29. DIAGNOSeS (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES | | 30. Additional remarks, INCLUDING OTHER INSURANCE COVERAGE on the date of service | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | 31. Identify all relevant clinical documentation that has been submitted to support medical necessity: If this is an out-of-state request, in addition to clinical documentation, include a letter of medical necessity that explains A) why services cannot be provided in state, B) what in-state services have already been exhausted, and C) the plan to transition care back to the state of Michigan. | | | | | H&P | Progress NoteS | Consultations | Labs | | Pathology report | operative reporT | Radiology Reports | Photos \*\***IncLude Photos for all cosmetic and reconstructive surgeries** | | DIScharge summary | Letter of Medical necessity | Other Diagnostics:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| 32. **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: | | | | | | | | | | | |
| **AUTHORITY:** Title XIX of the Social Security Act and Administrative rule 400.1104(a)  **COMPLETION:** Is Voluntary but is required if Medical Assistance program payment is desired. | | | The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy. | | | | | | | | |