Michigan Department of Health and Human Services

Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled DME, Medical Suppliers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers.

MDHHS 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 MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For 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 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 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:

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.

Michigan Department of Health and Human Services

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. 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)
12. DOES BENEFICIARY RESIDE IN A NURSING FACILITY? ☐ **YES** ☐ **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. BRAND NAME, MODEL CATALOG OR PART NUMBER	20. DESCRIPTION OF SERVICE	21. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE
01						
02						
03						
04						
05						
06						
07						

25. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	26. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

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

MDHHS USE ONLY

29. REVIEW ACTION:	30. CONSULTANT REMARKS
APPROVED ☐ RETURN ☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED ☐	

CONSULTANT SIGNATURE DATE