REFERRAL AND AUTHORIZATION FOR CSHCS DIAGNOSTIC EVALUATION

Michigan Department of Health and Human Services
Children's Special Health Care Services

INSTRUCTIONS

Purpose:

Children's Special Health Care Services (CSHCS) covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition, but the appropriate information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, **NOT FOR PROVIDING TREATMENT**. The Local Health Department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. The client might not have an I.D. number at the time of the appointment.

Local Health Department:

- Complete the form and give two copies to the client.
- Upload a copy to MDHHS-CSHCS Customer Support through the Document Management Portal (DMP). Document Type: Local Health Department; Document Title: Diagnostic Referral.
- Retain a copy for your file.
- Additional visits may occur as a result of the initial authorized visit for completion of the diagnostic evaluation.
- Additional visits MUST be for the same referral/diagnosis reasons listed on the "initial" authorization.

Client:

- Give one copy of this "Diagnostic Referral" to the authorized provider in order for the provider to bill for this service.
- You must also show your copy of this form to all other providers who are providing services related to this diagnostic referral (lab., x-ray, etc.).
- Keep a copy for your records.

Provider:

- Fax a copy of the **medical report** *and* a **copy** of this "Diagnostic Referral" form to: (517) 335-9491.

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Billing:

- All services and billing practices are subject to the policies described in the Michigan Medicaid Provider Manual available online at www.michigan.gov/medicaidproviders .
- All invoices must be Medicaid acceptable.
- Enter the word "**diagnostic**" in the Remarks section of the invoice.
- If the client has **private health insurance**, you must bill that insurance company **first**. Also, attach a copy of the Explanation of Benefits (EOB) to your invoice.
- As an enrolled provider, you have agreed to accept the Medicaid/CSHCS payment (plus private insurance payments where applicable) as payment in full.
- All claims must be submitted within **12 months** of the date of the service. Failure to do so will result in the denial of payment.
- If the client **has** Medicaid or CSHCS coverage on the date of service, send the **claim** to the Medicaid invoice processing system.
- If the client **is not** enrolled in Medicaid or CSHCS on the date of service, email or fax the **claim** *and* a **copy** of this "Diagnostic Referral" form to:

MDHHS-MSAPay-Inbox@michigan.gov (preferred method)

Fax #-517-241-6293

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Appointment Date	Time	Evaluation Type	Procedure Request	
		☐ First (initial)	☐ Laboratory	☐ Other
		☐ Follow-up	☐ Radiology	

IMPORTANT:

- **Additional visits may occur as a result of the initial authorized visit for completion of the diagnostic evaluation.**
- **Additional visits MUST be for the same referral/diagnosis reasons listed on the "initial" authorization.**
- **Form should be emailed to: MDHHS-MSAPay-Inbox@michigan.gov (preferred) – Or faxed to 517-241-6293**

CSHCS Authorized Provider Information

Name of Provider	Provider Phone Number ( ) -	Provider NPI Number	
Provider Address	City	State	Zip Code

Client Information

Name of Client (Last, First, Middle)	Date of Birth	Gender ☐ M ☐ F	Social Security Number - -	
Client Address	City		State MI	Zip Code
Health Insurance Company Name	Policy Number		Client County of Residence	
Policyholder Name	Relationship to Client		Family Phone Number ( ) -	
Client mihealth Card Number	CSHCS Enrolled? ☐ Yes ☐ No		If no, past Medicaid or CSHCS? ☐ Yes ☐ No	

Type of Evaluation/Reason(s) for Referral or Follow-Up

List the Reason(s) (i.e. history, signs and symptoms of suspected condition, etc.)

Responsible Relative/Court-Appointed Guardian Release of Information Authorization

- I am responsible for this child/client and I agree to this diagnostic evaluation.
- I agree to the release of ALL medical information resulting from the evaluation to the MDHHS, CSHCS Division.
- I know that this information may include information about any of the following:
  - Human Immune Deficiency Virus positivity (HIV+)
  - Acquired Immune Deficiency Syndrome (AIDS)

Responsible Relative/Court-Appointed Guardian Name (Print)	Responsible Relative/Court-Appointed Guardian Phone Number ( ) -
Responsible Relative/Court-Appointed Guardian Signature	Date Signed

FOR LOCAL HEALTH DEPARTMENT USE ONLY

Referred By	Agency Name	County
LHD Authorizing Signature	Date Signed	Agency Phone Number ( ) –

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title V of the Social Security Act. **COMPLETION:** Is voluntary, but is required if CSHCS payment is desired.