Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Durable Medical Equipment

Upload this request through the Provider Web Portal.
For questions regarding this form, call: (800) 525-2395.

DATE OF REQUEST: _____ /_____ /_____

REQUEST TYPE: ☐ Initial ☐ Continued Services ☐ Retrospective ☐ Unscheduled Revision

REQUIRED FOR RETROSPECTIVE REQUESTS ONLY
This recipient was determined eligible for Medicaid benefits on: _____ /_____ /_____

NOTES:

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:	Phone:	DOB:
Address:		
City:	State:	Zip Code:

INSURANCE INFORMATION
Medicare: ☐ Part A ☐ Part B ID#: _____ Other Insurance: _____
Additional Comments:_____

Does this recipient meet the standard Medicare criteria for the requested items? ☐ Yes ☐ No
(If "No," PA will be processed. The provider agrees to obtain a signed ABN for any service Medicare does not cover due to medical necessity.)

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:	Phone:	Fax:
Address:		
City:	State:	Zip Code:

SERVICING PROVIDER INFORMATION

Servicing Provider Name:		
NPI:	Phone:	Fax:
Address:		
City:	State:	Zip Code:
Contact Name:		

CLINICAL INFORMATION

Enter up to four ICD codes that apply: _____ _____ _____ _____

Additional Clinical Information:

Durable Medical Equipment

Recipient Name (last, first, MI):	Date of Request:

In the table below, use column 1 to enter the HCPCS code. Check column 2 if no HCPCS code is assigned from PDAC for the item being requested. Use column 3 to enter a description of the item. Enter the appropriate modifier and number of requested units in columns 4 and 5. In column 6, enter "R" if the equipment is for rent and "P" if the equipment is for purchase. If the item is covered by Medicare, enter a "Y" in column 7. If the item is not covered by Medicare, enter an "N" in column 7. Enter the requested "Start" and "End" dates for each item in columns 8 and 9.

1	2	3	4	5	6	7	8	9
HCPCS CODE	No HCPCS code	DESCRIPTION	MODIFIER	UNITS	"R" or "P"	MEDICARE Y or N	START DATE	END DATE
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							

Is this request for Healthy Kids (EPSDT) services? ☐ Yes ☐ No

REQUIRED FOR INPATIENT FACILITY PATIENTS AND PATIENTS BEING DISCHARGED FROM A FACILITY:

Enter date of discharge or anticipated date of discharge (as MM/DD/YYYY): _____

Provide discharge documents with date from the facility.

ORDERING PHYSICIAN'S SIGNATURE:_____

(Must match the Ordering Provider indicated on page 1 of this form.)

PRINT NAME: **DATE:** _____ /_____ /_____

THE FOLLOWING SIX ITEMS MUST BE ATTACHED TO THIS FORM:

(1) documentation of medical necessity from the servicing provider, (2) a medical order from the servicing provider, (3) a copy of the signed prescription, (4) the unaltered complete order form specific to the manufacturer and the model of the items being requested, (5) a copy of the equipment manufacturer's invoice, when applicable, and (6) documentation of a face-to-face clinical visit with the treating practitioner, relevant to the equipment/supplies requested, and matching the prescription within the last 6 months.