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:

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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.

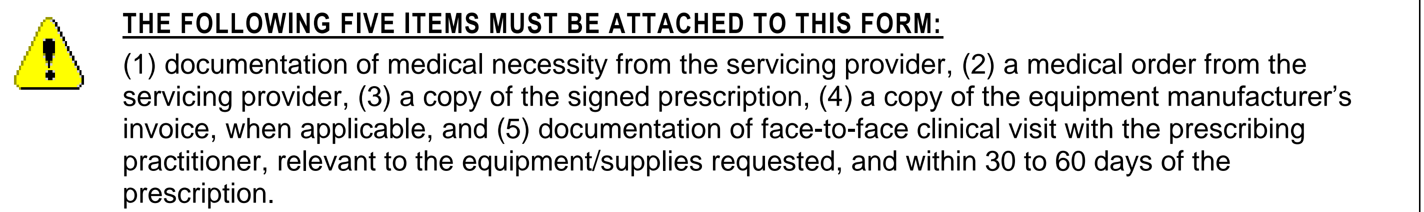
1	2	3	4	5	6	7	8	9
HCPCS CODE	No HCPCS code	DESCRIPTION	MODIFIER	UNITS	“R” or “P”	MEDICARE Y or N	START DATE	END DATE

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

REQUIRED FOR NURSING FACILITY (NF) PATIENTS AND PATIENTS BEING DISCHARGED FROM A NF:
Enter the date the recipient was or will be discharged from the nursing facility: ______ /______ /_______

ORDERING PHYSICIAN’S SIGNATURE:____
(Must match the Ordering Provider indicated on page 1 of this form.)

PRINT NAME: **DATE:** ______ /______ /________



THE FOLLOWING FIVE 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) a copy of the equipment manufacturer’s invoice, when applicable, and (5) documentation of face-to-face clinical visit with the prescribing practitioner, relevant to the equipment/supplies requested, and within 30 to 60 days of the prescription.

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.