Instructions for Completing Form FA-17

(Adult Day Health Care (ADHC) Prior Authorization Request)

Use the following instructions to complete and submit the Adult Day Health Care (ADHC) Prior Authorization Request form (FA-17) to Hewlett Packard Enterprise. Form FA-17 must be submitted for all Medicaid-eligible recipients prior to admission into Adult Day Health Care. All Adult Day Health Care services require prior authorization.

If the recipient is currently receiving ADHC services with another provider, form FA-29A (Request for Termination of Service) must be submitted along with form FA-17.

A request for review of a new authorization does not guarantee approval. Authorizations are based on Medicaid policy for coverage and medical necessity.

1. When faxing please fax in the following order: FA-17, MD note, universal needs assessment and care plan. Be sure that you are faxing with all documents facing right side up. Please check your individual fax machine.
   - The authorization will not show in the Provider Web Portal immediately. Please do not re-fax your request unless you are specifically asked to do so. You may contact customer service at (800) 525-2395 if you have questions regarding your request.

2. Complete the "DATE OF REQUEST" field with the date the form is faxed to Hewlett Packard Enterprise.

3. Indicate the type of authorization you are requesting.
   - Check "Initial" to request a new Medicaid payment authorization. You should request an Initial authorization when a recipient begins attending the ADHC facility or when Medicaid becomes the primary pay source for the recipient.
   - Check "Continuing" when the expiration date of a previously authorized period is near and the individual requires ongoing services.
   - Check "Revised" when the recipient's needs change during the current authorization period, for an increase or decrease in authorized days or hours per day. Please provide the updated MD note.

4. Complete the "RECIPIENT INFORMATION" section.
   a) Enter the recipient's last name, first name and middle initial.
   b) Enter the recipient's date of birth, Recipient ID, telephone number and mailing address.
   c) Verify that the recipient lives in an independent living situation by checking the correct box. A recipient is not eligible for ADHC services if he/she resides in (1) a State-licensed facility, such as a nursing facility or ICF/IID, or (2) a residential facility for groups which provides 24-hour services to seniors, and reimbursed by Medicaid, or (3) a supported living situation or arrangement that is 24 hours per day and reimbursed by Medicaid or another State Agency.

      Note: A supported living situation or arrangement can be reimbursed from one hour per day up to 24 hours per day. An individual is eligible for ADHC ONLY if services are not reimbursed during the time at ADHC.

5. Complete the "ADHC FACILITY INFORMATION" section.
   a) Enter the name of the ADHC facility requesting the authorization and the provider's name in the "Name" field.
   b) Enter the ADHC provider's 10-digit NPI. Do not include spaces, hyphens, etc.

c) Enter the telephone number, fax number and physical address of the ADHC facility.
d) Enter the name of the person completing the form and that person's professional title.
e) Enter the contact person's phone and fax numbers

6. Complete the "REQUESTED SERVICES" section. **Each field is required.**
   a) Indicate the requested begin date of service.
      1. This service requires prior authorization which means that the start date may not precede the date a complete request is received for review.
   b) Indicate the requested end date of service.
      1. Requests for ADHC are based on a monthly frequency, so the end date indicated must be the last day of a month.
      2. If the request has a start date of the 1st through the 15th of the month, the latest end date that may be requested is one year from the end of the previous month.
      3. If the request has a start date of the 16th through the 31st of the month, the latest end date that may be requested is one year from the end of the current month.
      4. Examples:
         - A start date of 03/15/2016 may have an end date as late as 02/28/2017.
         - A start date of 03/16/2016 may have an end date as late as 03/31/2017.
   c) Indicate the requested number of days per week.
   d) Indicate the ICD-10 code.
   e) Choose one of the two HCPCS codes (S5012 or S5100) for the services requested. This must be consistent with the MD note specifying 6 or more hours per day (S5102) or less than 6 hours per day or schedule varies (S5100).

7. Complete the "ADDITIONAL COMMENTS" section if applicable.

8. Complete the "RECIPIENT VERIFICATION AND SIGNATURE" section.
   a) Obtain the recipient's signature and date to verify he/she is choosing to attend your Adult Day Health Care Facility.
   b) A separate recipient verification form may be attached if the recipient signature is not on FA-17.

9. Fax form FA-17 and the required attachments to (855) 709-6846. For questions regarding form FA-17, call (800) 525-2395.

Additional Notes

Submitting Complete Information

If insufficient information is provided to authorize approval of the prior authorization request, the ADHC facility must provide the needed information within 24 hours upon request of Hewlett Packard Enterprise. Failure to comply will result in a technical denial due to provider non-compliance. When complete information is submitted, Hewlett Packard Enterprise makes a determination within five (5) business days.

Authorization Time Limits

ADHC services may be approved for a maximum of one year at a time. Retroactive authorization is prohibited.

Determination and Notification

Upon completion, submit this form to Hewlett Packard Enterprise. Requests are completed within five (5) business days. You may verify the authorization by using the Electronic Verification System (EVS) online at www.medicaid.nv.gov or the Automated Response System (ARS) at (800) 942-6511.