

AUTHORIZATION REQUEST

Purchase of Medical Care Services
DHHS – Controller's Office

Read Instructions on Back

1. Last Name		First Name		MI	12. Program		13. Authorization Number		
2. Patient SS #					14. POMCS Case Number				
3. Date of Birth		Month		Day	Year		4. Sex <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female		
5. Race		<input type="checkbox"/> 1. White		<input type="checkbox"/> 2. Black		<input type="checkbox"/> 3. American Indian		<input type="checkbox"/> 4. Asian	
		<input type="checkbox"/> 5. Native Hawaiian/Other Pacific Islander		<input type="checkbox"/> 6. Unknown		15. Hospital or Provider of Requested Service		Contact:	
Ethnicity: Hispanic or Latino Origin?		<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Unknown		Address:	
6. Preferred Language		_____		Select from the list on the back of this form		Phone #:		16. Requested dates of service	
7. County of Residence								17. Service is authorized for the following dates:	
8. Address		Street or RFD							
9. City		State		Zip Code					
10. Telephone # Home		Work							
11. Name of Parent or Guardian or Alternate Contact		Last		First		Middle		Phone #:	
18. Diagnostic Code/Diagnosis: Primary				Secondary					
19. Insurance or Third Party <small>(Attach copies of all Insurance Cards)</small>		Policy #		Policyholder		Claims Address			
Does this policy cover this service?		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Does this policy provide complete coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is this an HMO?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If an HMO, documentation is required. See reverse.			
20. COMPLETE FOR CANCER TREATMENT REQUESTS		A. Estimated five-year survival rate: _____%		B. Recurrent disease: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, attach statement about history.		21. COMPLETE FOR ALL HIV REQUESTS	
		C. Stage of disease or TNM classification _____		D. For Cervical Intraepithelial Neoplasia, check appropriate box: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe		A. CD ₄ Count _____		Date _____/_____/_____	
						B. Viral Load _____		Date _____/_____/_____	
22. CHECK SERVICE REQUESTED All programs do not cover all types of service.		A. <input type="checkbox"/> Inpatient Admission for _____ days		G. <input type="checkbox"/> Appliances/supplies. Give estimated cost in #23		H. <input type="checkbox"/> Formula _____ oral _____ enteral		I. <input type="checkbox"/> Home Nursing Care Tot. # _____ Freq. _____	
		B. <input type="checkbox"/> Inpatient Extension for _____ days		J. <input type="checkbox"/> Residential Care for _____ days		K. <input type="checkbox"/> Nutri. Counseling Tot. # _____ Freq. _____			
		C. <input type="checkbox"/> Outpt. (Hosp., Dial, FASC) for _____ visits		F. <input type="checkbox"/> Drugs related to program covered condition					
		D. <input type="checkbox"/> Physician's Office for _____ visits							
		E. <input type="checkbox"/> Therapy (PT, OT, SP) Tot. # _____ Freq. _____ Sess. Lgth. _____							
23. Describe service requested. Give estimated cost for each appliance. Required for EHDI Initial Hearing Aid.									
24. Ship equipment or medications to:		Street Address:		State Rd/RFD:		City:		State: Zip Code:	
25. Enter names and addresses of providers to whom a copy of approved Authorization should be sent for billing purposes. Do not include those listed in blocks 15 and 29.									
26A. Type or print physician's name		28. FOR ALL HIV REQUESTS Clinician's Information:		29. Requesting Office		Agency:			
26B. Physician's Signature		Phone #:		Contact:		Address:			
27. Other Clinician's Signature		Fax #:		Phone #:		Date:		Month Day Year	
		DEA #:							
		NC License #:							

INSTRUCTIONS

PURPOSE

This form is used to request authorization for reimbursement from the following programs: Adult Cystic Fibrosis, Cancer Control, Children's Special Health Services, EHDI Initial Hearing Aid, HIV Medications, Kidney and Sickle Cell. As of April 1999, the Migrant Health Program no longer requires Authorization Requests.

To qualify for payment, an applicant must be eligible for the program and an Authorization Request must be received within one year after the date of service. Processing time is reduced when this form is legible and complete. If requested, additional information must be received within one year after the date of service or within 30 days of notification, whichever is later. Incomplete forms will be returned.

Requests under EHDI-Initial Hearing Aid for Infants and Toddlers must be submitted by the third birthday. **Authorization Requests should be submitted without documentation if necessary to meet deadlines.** Requests will not be processed until all information is received.

INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM

6. Select one of the following languages and enter the 2 letter code in block 6 on the front of this form.

Arabic (AR)	Gujarati (GU)	Miao (MI)	Serbo-Croatian (SC)
Cambodian (CA)	Hindi (HI)	Mon-Khmer (MK)	Spanish (SP)
Chinese (CH)	Hmong (HM)	Other (OT)	Tagalog (TA)
English (EN)	Hungarian (HU)	Persian (PE)	Thai (TH)
French (FR)	Italian (IT)	Poland (PO)	Urdu (UR)
French Creole (FC)	Japanese (JA)	Portuguese (PG)	Vietnamese (VI)
German (GE)	Korean (KO)	Portuguese Creole (PC)	
Greek (GR)	Laotian (LA)	Russian (RU)	

10., 15., 28., 29. Include area code with phone number.

12. Specify program applied for.

13., 17. For POMCS use only. Do not complete these items.

18. Provide ICD-9 code if available. **Diagnosis should correspond to requested service.**

19. Provide complete insurance information. Attach copies of all insurance cards. Submit HMO denial or statement of benefits **if HMO does not cover or partially covers requested service.**

20. For cancer treatment only. Do not complete for diagnostic requests.

21. For HIV Program only. Provide most recent values.

22. **All Programs Do Not Cover All Types of Service.** Refer to individual program guidelines regarding coverage limitations.

ALL PROGRAMS

- Use separate forms for different types of service
- Use separate forms for each inpatient admission
- Use separate forms for each DME provider

CANCER CONTROL PROGRAM

- Use separate forms for diagnostic and treatment requests
- Designate follow up visits

23. Medical documentation is sometimes required. Refer to individual program guidelines regarding specific requirements.

24. Equipment is shipped to patient's home unless alternate address is listed here.

25. Include CAP case manager's name, address and signature if patient covered by CAP Medicaid.

26. Reserved for physician's name and signature. Cancer Control Program requires signature of attending physician. Children's Special Health Services requires original signature of program rostered physician. HIV Program allows signature of PA or Nurse Practitioner.

27. Enter signature of clinician, PA or practitioner specified by program.

28. For HIV Program, enter clinician's telephone number, fax number, DEA number and NC License number.

MAIL REQUESTS TO: Purchase of Medical Care Services
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, NC 27699-1904

Faxed Authorization Requests are not given priority. Requesting offices should contact POMCS regarding the need to expedite a request.

BILLING INSTRUCTIONS

After a service has been authorized and provided, claims should be submitted to the POMCS Claims Processing Unit, DHHS-Office of the Controller, 1904 Mail Service Center, Raleigh, NC 27699-1904. All third party payors must be billed. Providers must wait for payment or denial or wait up to six months, whichever comes first, before billing a POMCS program. All claims must be received within one year after the date of service in order to be paid. Additional billing information is available upon request.

HOW TO ORDER THIS FORM

Additional forms may be ordered by faxing a request to 919-733-0352 or calling 919-855-3672.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm