

## General Information for Authorization

|   |                   |         |                            |                         |                       |     |
|---|-------------------|---------|----------------------------|-------------------------|-----------------------|-----|
| Org                                     | 1.                |         |                            | Service Type            | 2.                    |     |
| <b>Client Information</b>               |                   |         |                            |                         |                       |     |
| Name                                    | 3.                |         |                            | Client ID               | 4.                    |     |
| Living Arrangements                     | 5.                |         |                            | Reference Auth #        | 6.                    |     |
| <b>Provider Information</b>             |                   |         |                            |                         |                       |     |
| Requesting NPI #                        | 7.                |         |                            | Requesting Fax #        | 8.                    |     |
| Billing NPI #                           | 9.                |         |                            | Name                    | 10.                   |     |
| Referring NPI #                         | 11.               |         |                            | Referring Fax #         | 12.                   |     |
| Service Start Date:                     | 13.               |         |                            |                         | 14.                   |     |
| <b>Service Request Information</b>      |                   |         |                            |                         |                       |     |
| Description of service being requested: |                   |         |                            | 15.                     |                       | 16. |
| 15.                                     |                   |         |                            | 16.                     |                       | 17. |
| 18. Serial/NEA or MEA #                 |                   |         |                            | 19.                     |                       |     |
| 20. Code Qualifier                      | 21. National Code | 22. Mod | 23. # Units/Days Requested | 24. \$ Amount Requested | 25. Part # (DME Only) |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
|   |                   |         |                            |                         |                       |     |
| <b>Medical Information</b>              |                   |         |                            |                         |                       |     |
| Diagnosis Code                          | 27.               |         | Diagnosis name             | 28.                     |                       |     |
| Place of Service Code                   | 29.               |         |                            |                         |                       |     |
| 30. Comments:                           |                   |         |                            |                         |                       |     |

[www.hca.wa.gov/medicaid/forms/Pages/Index.aspx](http://www.hca.wa.gov/medicaid/forms/Pages/Index.aspx)

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. **HIPAA Compliance:** Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

**Instructions to fill out the General Information for Authorization form, HCA 13-835**

| FIELD                            | NAME   | ACTION  |                                   |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
|----------------------------------|--|---|-----------------------------------|---------|----|----------------|-----|------------|-----|-----------------|-----|--------------|------|-----------------|----|---------------------|-----|-------------------------------|-----|-----------------|-----|-------------|------|----------------------------|-----|-------------|----|------------------------|------|-------------|-----|--|----|-------------------|--|--|------|-------------------|----|---------------------|----|----------------------|----|----------------|-----|---------------|-----|----------------------------|----|---------------------|-----|----------------------------|------|---------------|----|-----------------|------|-------------------|---|-------------|----|-------------------|----|--------------------------|-----|-----------------------------|-----|--------------------------|------|---------------------------|-----|--|-----|-----------------------------|------|-------------|-----|--------------------|------|------------------------------|------|-----------------|----|------------|----|--------------------|----|-------------------|----|-------------------|----|--------------------|-----|------------------------------|----|--------------------------|-----|-------------------------------|-----|---------------------------------|----|---------------------|------|----------------------------|------|--------------|-----|---------------------------------|----|----------------|--|--|----|----------------------|--|--|------|-----------------------------------|--|--|------|-------------------|
| <b>ALL FIELDS MUST BE TYPED.</b> |  |   |                                   |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| 1                                | Org (Required)   | <p>Enter the Number that Matches the Program/Unit for the Request</p> <p>501 – Dental<br/>                     502 – Durable Medical Equipment (DME)<br/>                     504 – Home Health<br/>                     505 – Hospice<br/>                     506 – Inpatient Hospital<br/>                     508 – Medical<br/>                     509 – Medical Nutrition<br/>                     511 – Outpt Proc/Diag<br/>                     513 – Physical Medicine &amp; Rehabilitation (PM &amp; R)<br/>                     514 – Aging and Long-Term Support Administration (AL TSA)<br/>                     518 – LTAC<br/>                     519 – Respiratory<br/>                     521 – Maternity Support/Infant Case Management<br/>                     524 – Concurrent Care<br/>                     525 – ABA Services<br/>                     526 – Complex Rehabilitation Technology (CRT)<br/>                     527 – Chemical-Using Pregnant (CUP) Women Program</p>   |                                   |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| 2                                | Service Type (Required)  | <p>Enter the letter(s) in all CAPS that represent the service type you are requesting.<br/>                     If you selected “501 – <b>Dental</b>” for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>ASC</td> <td>for ASC</td> <td>IP</td> <td>for In-Patient</td> </tr> <tr> <td>CWN</td> <td>for Crowns</td> <td>ODC</td> <td>for Orthodontic</td> </tr> <tr> <td>DEN</td> <td>for Dentures</td> <td>OUTP</td> <td>for Out-Patient</td> </tr> <tr> <td>DP</td> <td>for Denture/Partial</td> <td>PSM</td> <td>for Perio-Scaling/Maintenance</td> </tr> <tr> <td>EXT</td> <td>for Extractions</td> <td>PTL</td> <td>for Partial</td> </tr> <tr> <td>EXTD</td> <td>for Extractions w/Dentures</td> <td>RBS</td> <td>for Rebases</td> </tr> <tr> <td>GA</td> <td>for General Anesthesia</td> <td>RLNS</td> <td>for Relines</td> </tr> <tr> <td>GAE</td> <td>for General Anesthesia<br/>w/ extractions</td> <td>TC</td> <td>for Transfer Case</td> </tr> <tr> <td></td> <td></td> <td>MISC</td> <td>for Miscellaneous</td> </tr> </table> <p>If you selected “502 – <b>Durable Medical Equipment (DME)</b>” for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>AA</td> <td>for Ambulatory Aids</td> <td>OS</td> <td>for Orthopedic Shoes</td> </tr> <tr> <td>BB</td> <td>for Bath Bench</td> <td>OTC</td> <td>for Orthotics</td> </tr> <tr> <td>BEM</td> <td>for Bath Equipment (misc.)</td> <td>OP</td> <td>for Ostomy Products</td> </tr> <tr> <td>BGS</td> <td>for Bone Growth Stimulator</td> <td>ODME</td> <td>for Other DME</td> </tr> <tr> <td>BP</td> <td>for Breast Pump</td> <td>OTRR</td> <td>for Other Repairs</td> </tr> <tr> <td>C</td> <td>for Commode</td> <td>PL</td> <td>for Patient Lifts</td> </tr> <tr> <td>CG</td> <td>for Compression Garments</td> <td>PWH</td> <td>for Power Wheelchair - Home</td> </tr> <tr> <td>CSC</td> <td>for Commode/Shower Chair</td> <td>PWNF</td> <td>for Power Wheelchair – NF</td> </tr> <tr> <td>DTS</td> <td>for Diabetic Testing<br/>Supplies (See Pharmacy<br/>Billing Instructions for POS<br/>Billing)</td> <td>PWR</td> <td>for Power Wheelchair Repair</td> </tr> <tr> <td>ERSO</td> <td>for ERSO-PA</td> <td>PRS</td> <td>for Prone Standers</td> </tr> <tr> <td>FSFS</td> <td>for Floor Sitter/Feeder Seat</td> <td>PROS</td> <td>for Prosthetics</td> </tr> <tr> <td>GL</td> <td>for Gloves</td> <td>RE</td> <td>for Room Equipment</td> </tr> <tr> <td>HB</td> <td>for Hospital Beds</td> <td>SC</td> <td>for Shower Chairs</td> </tr> <tr> <td>HC</td> <td>for Hospital Cribs</td> <td>SBS</td> <td>for Specialty “Beds/Surfaces</td> </tr> <tr> <td>IS</td> <td>for Incontinent Supplies</td> <td>SGD</td> <td>for Speech Generating Devices</td> </tr> <tr> <td>MWH</td> <td>for Manual Wheelchair -<br/>Home</td> <td>SF</td> <td>for Standing Frames</td> </tr> <tr> <td>MWNF</td> <td>for Manual Wheelchair – NF</td> <td>STND</td> <td>for Standers</td> </tr> <tr> <td>MWR</td> <td>for Manual Wheelchair<br/>Repair</td> <td>TU</td> <td>for TENS Units</td> </tr> <tr> <td></td> <td></td> <td>US</td> <td>for Urinary Supplies</td> </tr> <tr> <td></td> <td></td> <td>WDCS</td> <td>for VAC/Wound - decubiti supplies</td> </tr> <tr> <td></td> <td></td> <td>MISC</td> <td>for Miscellaneous</td> </tr> </table> | ASC                               | for ASC | IP | for In-Patient | CWN | for Crowns | ODC | for Orthodontic | DEN | for Dentures | OUTP | for Out-Patient | DP | for Denture/Partial | PSM | for Perio-Scaling/Maintenance | EXT | for Extractions | PTL | for Partial | EXTD | for Extractions w/Dentures | RBS | for Rebases | GA | for General Anesthesia | RLNS | for Relines | GAE | for General Anesthesia<br>w/ extractions | TC | for Transfer Case |  |  | MISC | for Miscellaneous | AA | for Ambulatory Aids | OS | for Orthopedic Shoes | BB | for Bath Bench | OTC | for Orthotics | BEM | for Bath Equipment (misc.) | OP | for Ostomy Products | BGS | for Bone Growth Stimulator | ODME | for Other DME | BP | for Breast Pump | OTRR | for Other Repairs | C | for Commode | PL | for Patient Lifts | CG | for Compression Garments | PWH | for Power Wheelchair - Home | CSC | for Commode/Shower Chair | PWNF | for Power Wheelchair – NF | DTS | for Diabetic Testing<br>Supplies (See Pharmacy<br>Billing Instructions for POS<br>Billing) | PWR | for Power Wheelchair Repair | ERSO | for ERSO-PA | PRS | for Prone Standers | FSFS | for Floor Sitter/Feeder Seat | PROS | for Prosthetics | GL | for Gloves | RE | for Room Equipment | HB | for Hospital Beds | SC | for Shower Chairs | HC | for Hospital Cribs | SBS | for Specialty “Beds/Surfaces | IS | for Incontinent Supplies | SGD | for Speech Generating Devices | MWH | for Manual Wheelchair -<br>Home | SF | for Standing Frames | MWNF | for Manual Wheelchair – NF | STND | for Standers | MWR | for Manual Wheelchair<br>Repair | TU | for TENS Units |  |  | US | for Urinary Supplies |  |  | WDCS | for VAC/Wound - decubiti supplies |  |  | MISC | for Miscellaneous |
| ASC                              | for ASC  | IP  | for In-Patient                    |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| CWN                              | for Crowns   | ODC   | for Orthodontic                   |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| DEN                              | for Dentures   | OUTP  | for Out-Patient                   |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| DP                               | for Denture/Partial  | PSM   | for Perio-Scaling/Maintenance     |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| EXT                              | for Extractions  | PTL   | for Partial                       |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| EXTD                             | for Extractions w/Dentures   | RBS   | for Rebases                       |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| GA                               | for General Anesthesia   | RLNS  | for Relines                       |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| GAE                              | for General Anesthesia<br>w/ extractions   | TC  | for Transfer Case                 |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
|                                  |  | MISC  | for Miscellaneous                 |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| AA                               | for Ambulatory Aids  | OS  | for Orthopedic Shoes              |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| BB                               | for Bath Bench   | OTC   | for Orthotics                     |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| BEM                              | for Bath Equipment (misc.)   | OP  | for Ostomy Products               |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| BGS                              | for Bone Growth Stimulator   | ODME  | for Other DME                     |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| BP                               | for Breast Pump  | OTRR  | for Other Repairs                 |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| C                                | for Commode  | PL  | for Patient Lifts                 |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| CG                               | for Compression Garments   | PWH   | for Power Wheelchair - Home       |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| CSC                              | for Commode/Shower Chair   | PWNF  | for Power Wheelchair – NF         |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| DTS                              | for Diabetic Testing<br>Supplies (See Pharmacy<br>Billing Instructions for POS<br>Billing) | PWR   | for Power Wheelchair Repair       |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| ERSO                             | for ERSO-PA  | PRS   | for Prone Standers                |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| FSFS                             | for Floor Sitter/Feeder Seat   | PROS  | for Prosthetics                   |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| GL                               | for Gloves   | RE  | for Room Equipment                |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| HB                               | for Hospital Beds  | SC  | for Shower Chairs                 |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| HC                               | for Hospital Cribs   | SBS   | for Specialty “Beds/Surfaces      |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| IS                               | for Incontinent Supplies   | SGD   | for Speech Generating Devices     |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| MWH                              | for Manual Wheelchair -<br>Home  | SF  | for Standing Frames               |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| MWNF                             | for Manual Wheelchair – NF   | STND  | for Standers                      |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
| MWR                              | for Manual Wheelchair<br>Repair  | TU  | for TENS Units                    |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
|                                  |  | US  | for Urinary Supplies              |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
|                                  |  | WDCS  | for VAC/Wound - decubiti supplies |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |
|                                  |  | MISC  | for Miscellaneous                 |         |    |                |     |            |     |                 |     |              |      |                 |    |                     |     |                               |     |                 |     |             |      |                            |     |             |    |                        |      |             |     |  |    |                   |  |  |      |                   |    |                     |    |                      |    |                |     |               |     |                            |    |                     |     |                            |      |               |    |                 |      |                   |   |             |    |                   |    |                          |     |                             |     |                          |      |                           |     |  |     |                             |      |             |     |                    |      |                              |      |                 |    |            |    |                    |    |                   |    |                   |    |                    |     |                              |    |                          |     |                               |     |                                 |    |                     |      |                            |      |              |     |                                 |    |                |  |  |    |                      |  |  |      |                                   |  |  |      |                   |



**Instructions to fill out the General Information for Authorization form, HCA 13-835**

| <b>FIELD</b>                       | <b>NAME</b>                                   | <b>ACTION</b>   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
|------------------------------------|---|---|---------------------|----------------|------------------|------------------|-------------------|---------------|------------------|-------------|------------------|---------------------------------|----------------------------------|--------------------------------|---------------------------------|----------------------------------|-----------------------------------|-----------------------------------|------------------------------------|--|
|                                    |   | <b>ALL FIELDS MUST BE TYPED.</b>  |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| 2                                  | Service Type <b>(Required)</b><br>(Continued) | <p>If you selected “514 – <b>Aging and Long-Term Support Administration (AL TSA)</b> for field #1, please select one of the following codes for this field:</p> <p>PDN for Private Duty Nursing<br/>MISC for Miscellaneous</p> <p>If you selected “518 – <b>LTAC</b>” for field #1, please select one of the following codes for this field:</p> <p>ERSO for ERSO-PA<br/>LTAC for LTAC<br/>O for Other</p> <p>If you selected “519 – <b>Respiratory</b>” for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>CPAP for CPAP/BiPAP</td> <td>OXY for Oxygen</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>SUP for Supplies</td> </tr> <tr> <td>NEB for Nebulizer</td> <td>VENT for Vent</td> </tr> <tr> <td>OXM for Oximeter</td> <td>O for Other</td> </tr> </table> <p>If you selected “521 – <b>Maternity Support/Infant Case Management (MSS)</b>” for field #1, please select one of the following codes for this field:</p> <p>ICM for Infant Case Management<br/>PO for Post Pregnancy Only<br/>PPP for Prenatal/Post Pregnancy<br/>O for Other</p> <p>If you selected “524 – <b>Concurrent Care</b>” (for children on Hospice) for field #1, please select one of the following codes for this field:</p> <p>CC for Concurrent Care Services</p> <p>Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected “525 – <b>ABA Services</b>” for field #1, please select one of the following codes for this field:</p> <p>IH for In Home/Community/Office<br/>DAYP for Day Program</p> <p>If you selected “526 – <b>Complex Rehabilitation Technology</b>” (CRT) for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>ERSO for ERSO-PA</td> <td>PWH for Power Wheelchair - Home</td> </tr> <tr> <td>MWH for Manual Wheelchair - Home</td> <td>PWNF for Power Wheelchair – NF</td> </tr> <tr> <td>MWNF for Manual Wheelchair - NF</td> <td>PWR for Power Wheelchair Repairs</td> </tr> <tr> <td>MWR for Manual Wheelchair Repairs</td> <td>PWS for Power Wheelchair Supplies</td> </tr> <tr> <td>MWS for Manual Wheelchair Supplies</td> <td></td> </tr> </table> <p>If you selected “527 – <b>Chemical-Using Pregnant (CUP) Women Program</b>” for field #1, please select one of the following codes for this field:</p> <p>DX for Detox<br/>DM for Detox/Medical Stabilization<br/>MS for Medical Stabilization</p> | CPAP for CPAP/BiPAP | OXY for Oxygen | ERSO for ERSO-PA | SUP for Supplies | NEB for Nebulizer | VENT for Vent | OXM for Oximeter | O for Other | ERSO for ERSO-PA | PWH for Power Wheelchair - Home | MWH for Manual Wheelchair - Home | PWNF for Power Wheelchair – NF | MWNF for Manual Wheelchair - NF | PWR for Power Wheelchair Repairs | MWR for Manual Wheelchair Repairs | PWS for Power Wheelchair Supplies | MWS for Manual Wheelchair Supplies |  |
| CPAP for CPAP/BiPAP                | OXY for Oxygen                                |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| ERSO for ERSO-PA                   | SUP for Supplies                              |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| NEB for Nebulizer                  | VENT for Vent                                 |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| OXM for Oximeter                   | O for Other                                   |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| ERSO for ERSO-PA                   | PWH for Power Wheelchair - Home               |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| MWH for Manual Wheelchair - Home   | PWNF for Power Wheelchair – NF                |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| MWNF for Manual Wheelchair - NF    | PWR for Power Wheelchair Repairs              |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| MWR for Manual Wheelchair Repairs  | PWS for Power Wheelchair Supplies             |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |
| MWS for Manual Wheelchair Supplies |   |   |                     |                |                  |                  |                   |               |                  |             |                  |                                 |                                  |                                |                                 |                                  |                                   |                                   |                                    |  |

## Instructions to fill out the General Information for Authorization form, HCA 13-835

| FIELD | NAME   | ACTION  |
|-------|--|---|
|       |  | <b>ALL FIELDS MUST BE TYPED.</b>  |
| 3     | Name: <b>(Required)</b>  | Enter the last name, first name, and middle initial of the patient you are requesting authorization for.  |
| 4     | Client ID: <b>(Required)</b>                                   | Enter the client ID - 9 numbers followed by WA.<br>For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): <ul style="list-style-type: none"> <li>▪ You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit.</li> <li>▪ A reference PA will be built with a placeholder client ID.</li> <li>▪ If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID.</li> </ul> The PA will be updated and you will be able to bill the services approved. |
| 5     | Living Arrangements  | Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.  |
| 6     | Reference Auth #   | If requesting a change or extension to an existing authorization, please indicate the number in this field.   |
| 7     | Requesting NPI #: <b>(Required)</b>                            | The 10 digit number that has been assigned to the requesting provider by CMS.   |
| 8     | Requesting Fax#  | The fax number of the requesting provider.  |
| 9     | Billing NPI #: <b>(Required)</b>                               | The 10 digit number that has been assigned to the billing provider by CMS.  |
| 10    | Name   | The name of the billing/servicing provider.   |
| 11    | Referring NPI #  | The 10 digit number that has been assigned to the referring provider by CMS.  |
| 12    | Referring Fax #  | The fax number of the referring provider.   |
| 13    | Service Start Date   | The date the service is planned to be started if known.   |
| 15    | Description of service being requested: <b>(Required)</b> .    | A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).   |
| 18    | Serial/NEA or MEA#: Required for all DME repairs.              | Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.   |
| 20    | Code Qualifier: <b>(Required)</b> .                            | Enter the letter corresponding to the code from below:<br>T - CDT Proc Code<br>C - CPT Proc Code<br>D - DRG<br>P - HCPCS Proc Code<br>I - ICD-9/10 Proc Code<br>R - Rev Code<br>N - NDC-National Drug Code<br>S – ICD-9/10 Diagnosis Code   |
| 21    | National Code: <b>(Required)</b> .                             | Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.   |
| 22    | Modifier   | When appropriate enter a modifier.  |
| 23    | # Units/Days Requested: <b>(Units or \$ required)</b> .        | Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <a href="#">Medicaid Provider Guide</a> for the appropriate unit/day designation for the service code entered).   |
| 24    | \$ Amount Requested: <b>(Units or \$ required)</b> .           | Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <a href="#">Medicaid Provider Guide</a> and <a href="#">fee schedules</a> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00).  |
| 25    | Part # (DME only): <b>(Required for all requested codes)</b> . | Enter the manufacturer part # of the item requested.  |

**Instructions to fill out the General Information for Authorization form, HCA 13-835**

| FIELD                    | NAME  | ACTION   |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
|--------------------------|---|--|--------------------------|-----------------------|---|----------|---|--------|---|------------------|---|--|---|---|---|-----------------------------------|---|------------------------------------|---|------------------------------|----|--------|----|------|----|--------------------------|----|------------|----|-------------|----|-------------------|----|------------------------------|----|----------------------|----|--------------------|----|---------------------|----|---------------------------|----|----------------------------|----|-----------------|----|-----------------------------|----|--------------------------|----|------------------|----|-------------------------|----|---------|----|------------------|----|--------------------------|----|--------------------|----|-----------------------------------|----|--------------------------------|
|                          |   | <b>ALL FIELDS MUST BE TYPED.</b>   |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 26                       | Tooth or Quad#:<br><b>(Required for dental requests).</b> | Enter the tooth or quad number as listed below:<br>QUAD<br>00 – full mouth<br>01 – upper arch<br>02 – lower arch<br>10 – upper right quadrant<br>20 – upper left quadrant<br>30 – lower left quadrant<br>40 – lower right quadrant<br>Tooth # 1-32, A-T, AS-TS, and 51-82  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 27                       | Diagnosis Code  | Enter appropriate diagnosis code for condition.  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 28                       | Diagnosis name  | Short description of the diagnosis.  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 29                       | Place of Service  | Enter the appropriate two digit place of service code.   |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
|                          |   | <table border="1"> <thead> <tr> <th>Place of Service Code(s)</th> <th>Place of Service Name</th> </tr> </thead> <tbody> <tr><td>1</td><td>Pharmacy</td></tr> <tr><td>3</td><td>School</td></tr> <tr><td>4</td><td>Homeless Shelter</td></tr> <tr><td>5</td><td>Indian Health Service Free-standing Facility</td></tr> <tr><td>6</td><td>Indian Health Service Provider-based Facility</td></tr> <tr><td>7</td><td>Tribal 638 Free-standing Facility</td></tr> <tr><td>8</td><td>Tribal 638 Provider-based Facility</td></tr> <tr><td>9</td><td>Prison-Correctional Facility</td></tr> <tr><td>11</td><td>Office</td></tr> <tr><td>12</td><td>Home</td></tr> <tr><td>13</td><td>Assisted Living Facility</td></tr> <tr><td>14</td><td>Group Home</td></tr> <tr><td>15</td><td>Mobile Unit</td></tr> <tr><td>16</td><td>Temporary Lodging</td></tr> <tr><td>17</td><td>Walk in Retail Health Clinic</td></tr> <tr><td>20</td><td>Urgent Care Facility</td></tr> <tr><td>21</td><td>Inpatient Hospital</td></tr> <tr><td>22</td><td>Outpatient Hospital</td></tr> <tr><td>23</td><td>Emergency Room – Hospital</td></tr> <tr><td>24</td><td>Ambulatory Surgical Center</td></tr> <tr><td>25</td><td>Birthing Center</td></tr> <tr><td>26</td><td>Military Treatment Facility</td></tr> <tr><td>31</td><td>Skilled Nursing Facility</td></tr> <tr><td>32</td><td>Nursing Facility</td></tr> <tr><td>33</td><td>Custodial Care Facility</td></tr> <tr><td>34</td><td>Hospice</td></tr> <tr><td>41</td><td>Ambulance - Land</td></tr> <tr><td>42</td><td>Ambulance – Air or Water</td></tr> <tr><td>49</td><td>Independent Clinic</td></tr> <tr><td>50</td><td>Federally Qualified Health Center</td></tr> <tr><td>51</td><td>Inpatient Psychiatric Facility</td></tr> </tbody> </table> | Place of Service Code(s) | Place of Service Name | 1 | Pharmacy | 3 | School | 4 | Homeless Shelter | 5 | Indian Health Service Free-standing Facility | 6 | Indian Health Service Provider-based Facility | 7 | Tribal 638 Free-standing Facility | 8 | Tribal 638 Provider-based Facility | 9 | Prison-Correctional Facility | 11 | Office | 12 | Home | 13 | Assisted Living Facility | 14 | Group Home | 15 | Mobile Unit | 16 | Temporary Lodging | 17 | Walk in Retail Health Clinic | 20 | Urgent Care Facility | 21 | Inpatient Hospital | 22 | Outpatient Hospital | 23 | Emergency Room – Hospital | 24 | Ambulatory Surgical Center | 25 | Birthing Center | 26 | Military Treatment Facility | 31 | Skilled Nursing Facility | 32 | Nursing Facility | 33 | Custodial Care Facility | 34 | Hospice | 41 | Ambulance - Land | 42 | Ambulance – Air or Water | 49 | Independent Clinic | 50 | Federally Qualified Health Center | 51 | Inpatient Psychiatric Facility |
| Place of Service Code(s) | Place of Service Name                                     |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 1                        | Pharmacy  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 3                        | School  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 4                        | Homeless Shelter  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 5                        | Indian Health Service Free-standing Facility              |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 6                        | Indian Health Service Provider-based Facility             |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 7                        | Tribal 638 Free-standing Facility                         |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 8                        | Tribal 638 Provider-based Facility                        |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 9                        | Prison-Correctional Facility                              |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 11                       | Office  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 12                       | Home  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 13                       | Assisted Living Facility                                  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 14                       | Group Home  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 15                       | Mobile Unit   |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 16                       | Temporary Lodging   |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 17                       | Walk in Retail Health Clinic                              |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 20                       | Urgent Care Facility                                      |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 21                       | Inpatient Hospital  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 22                       | Outpatient Hospital                                       |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 23                       | Emergency Room – Hospital                                 |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 24                       | Ambulatory Surgical Center                                |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 25                       | Birthing Center   |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 26                       | Military Treatment Facility                               |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 31                       | Skilled Nursing Facility                                  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 32                       | Nursing Facility  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 33                       | Custodial Care Facility                                   |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 34                       | Hospice   |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 41                       | Ambulance - Land  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 42                       | Ambulance – Air or Water                                  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 49                       | Independent Clinic  |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 50                       | Federally Qualified Health Center                         |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |
| 51                       | Inpatient Psychiatric Facility                            |  |                          |                       |   |          |   |        |   |                  |   |  |   |   |   |                                   |   |                                    |   |                              |    |        |    |      |    |                          |    |            |    |             |    |                   |    |                              |    |                      |    |                    |    |                     |    |                           |    |                            |    |                 |    |                             |    |                          |    |                  |    |                         |    |         |    |                  |    |                          |    |                    |    |                                   |    |                                |

**Instructions to fill out the General Information for Authorization form, HCA 13-835**

| FIELD                            | NAME             | ACTION  |  |
|----------------------------------|------------------|---|--|
| <b>ALL FIELDS MUST BE TYPED.</b> |                  |   |  |
| 29                               | Place of Service | 52  | Psychiatric Facility-Partial Hospitalization       |
|                                  |                  | 53  | Community Mental Health Center                     |
|                                  |                  | 55  | Residential Substance Abuse Treatment Facility     |
|                                  |                  | 56  | Psychiatric Residential Treatment Center           |
|                                  |                  | 57  | Non-residential Substance Abuse Treatment Facility |
|                                  |                  | 60  | Mass Immunization Center                           |
|                                  |                  | 61  | Comprehensive Inpatient Rehabilitation Facility    |
|                                  |                  | 62  | Comprehensive Outpatient Rehabilitation Facility   |
|                                  |                  | 65  | End-Stage Renal Disease Treatment Facility         |
|                                  |                  | 71  | Public Health Clinic                               |
|                                  |                  | 72  | Rural Health Clinic                                |
|                                  |                  | 81  | Independent Laboratory                             |
|                                  |                  | 99  | Other Place of Service                             |
| 30                               | Comments         | Enter any free form information you deem necessary. |  |