
Requesting Prior Authorization

Complete the ProviderOne Authorization Intake Process

This Guide Is Designed to Prepare You to:

- Locate the General Information for Authorization form, HCA 13-835
- Fill out the Authorization Form with the Required Information
- Navigate ProviderOne Paper and Fax Intake Process
- Check on the Status of Your Authorization Request
- Submit Additional Supporting Documentation with Agency Cover Sheets When Needed

Note: This chapter does not apply to pharmacy authorization, Long Term Acute Care (LTAC), or Physical Medicine and Rehabilitation (PM&R) admissions.

Why Requesting Prior Authorization Is an Important Activity?

Some Medicaid-covered procedures require Prior Authorization. If you need to determine if the service requires authorization, please review the [“Client Eligibility, Benefit Packages, and Coverage Limits”](#) chapter of the ProviderOne Billing and Resource Guide. This chapter will discuss how to submit your authorization request. Submitting your request according to the Agency’s guidelines will help expedite the authorization process.

Note: Authorization for services does not guarantee payment. Providers must meet administrative requirements (e.g. client eligibility, claim timelines, third-party insurance, etc.) before the Agency pays for services.

Disclaimer

A contract, known as the Core Provider Agreement, governs the relationship between the Agency and Medical Assistance providers. The Core Provider Agreement's terms and conditions incorporate federal laws, rules and regulations, state law, Agency rules and regulations, and Agency program policies, numbered memoranda, and billing instructions, including this Guide. Providers must submit a claim in accordance with the Agency rules, policies, numbered memoranda, and billing instructions in effect at the time they provided the service.

Every effort has been made to ensure this Guide's accuracy. However, in the unlikely event of an actual or apparent conflict between this document and an Agency rule, the Agency rule controls.

Requesting Prior Authorization

The Key Steps

- 1. Complete Authorization Form 13-835**
- 2. Submit Authorization Request to the Agency with required back-up**
- 3. Check the Status of Your Request**
- 4. Send in Additional Documentation if Requested by the Agency**

Key Step

1

Complete Authorization Form 13-835

Why

To begin the authorization process you need to complete General Information for Authorization form, HCA [13-835](#). ProviderOne can begin processing the authorization request once the Agency receives this form filled out correctly.

How

Access the online authorization form 13-835 at <http://hrsa.dshs.wa.gov/mpforms.shtml>. Forms are listed in numerical order. Scroll down to find form 13-835. Providers can also find the form by using “Control F” and enter 13-835 in the find window.

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Type in the required fields before printing the form. The table below describes what information should be placed in each field. This table is also located online after the authorization form.

Field	Name	Action																																										
1	Org (Required)	<p>ALL FIELDS MUST BE TYPED</p> <p>Enter the number that matches the Program/Unit for the request</p> <p>501 - Dental 502 - Durable Medical Equipment (DME) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 508 - Medical 509 - Medical Nutrition 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 518 – LTAC 519 – Respiratory 521 – Maternity Support</p>																																										
		<p>Enter the letter(s) in all CAPS that represent the service type you are requesting.</p> <p>If you selected “501 – Dental” for field #1, select one of the following codes for this field:</p> <table border="0"> <tr> <td>ASC for ASC</td> <td>OUTP for Out-Patient</td> </tr> <tr> <td>CWN for Crowns</td> <td>PSM for Perio-Scaling/Maintenance</td> </tr> <tr> <td>DEN for Dentures</td> <td>PTL for Partial</td> </tr> <tr> <td>DP for Denture/Partial</td> <td>RBS for Rebases</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>RLNS for Relines</td> </tr> <tr> <td>IP for In-Patient</td> <td>MISC for Miscellaneous</td> </tr> <tr> <td>ODC for Orthodontic</td> <td></td> </tr> </table> <hr/> <p>If you selected “502 – Durable Medical Equipment (DME)” for field #1, select one of the following codes for this field:</p> <table border="0"> <tr> <td>AA for Ambulatory Aids</td> <td>OS for Orthopedic Shoes</td> </tr> <tr> <td>BB for Bath Bench</td> <td>OTC for Orthotics</td> </tr> <tr> <td>BEM for Bath Equipment (misc.)</td> <td>OP for Ostomy Products</td> </tr> <tr> <td>BGS for Bone Growth Stimulator</td> <td>ODME for Other DME</td> </tr> <tr> <td>BP for Breast Pump</td> <td>OTRR for Other Repairs</td> </tr> <tr> <td>C for Commode</td> <td>PL for Patient Lifts</td> </tr> <tr> <td>CG for Compression Garments</td> <td>PWH for Power Wheelchair - Home</td> </tr> <tr> <td>CSC for Commode/Shower Chair</td> <td>PWNF for Power Wheelchair – NF</td> </tr> <tr> <td>DTS for Diabetic Testing Supplies (See Pharmacy Medicaid Provider Guides for POS Billing)</td> <td>PWR for Power Wheelchair Repair</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>PRS for Prone Standers</td> </tr> <tr> <td>FSFS for Floor Sitter/Feeder</td> <td>PROS for Prosthetics</td> </tr> <tr> <td></td> <td>RE for Room Equipment</td> </tr> <tr> <td></td> <td>SC for Shower Chairs</td> </tr> <tr> <td></td> <td>SBS for Specialty “Beds/Surfaces</td> </tr> <tr> <td></td> <td>SGD for Speech Generating Devices</td> </tr> </table>	ASC for ASC	OUTP for Out-Patient	CWN for Crowns	PSM for Perio-Scaling/Maintenance	DEN for Dentures	PTL for Partial	DP for Denture/Partial	RBS for Rebases	ERSO for ERSO-PA	RLNS for Relines	IP for In-Patient	MISC for Miscellaneous	ODC for Orthodontic		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 Supplies (See Pharmacy Medicaid Provider Guides for POS Billing)	PWR for Power Wheelchair Repair	ERSO for ERSO-PA	PRS for Prone Standers	FSFS for Floor Sitter/Feeder	PROS for Prosthetics		RE for Room Equipment		SC for Shower Chairs		SBS for Specialty “Beds/Surfaces
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Field	Name	Action
		Seat HB for Hospital Beds HC for Hospital Cribs IS for Incontinent Supplies MWH for Manual Wheelchair - Home MWNF for Manual Wheelchair – NF MWR for Manual Wheelchair Repair <hr/> SF for Standing Frames STND for Standers TU for TENS Units US for Urinary Supplies WDCS for VAC/Wound - decubiti supplies MISC for Miscellaneous <hr/> If you selected “504 – Home Health ” for field #1, select one of the following codes for this field: ERSO for ERSO-PA HH for Home Health MISC for Miscellaneous T for Therapies (PT / OT / ST) <hr/> If you selected “505 – Hospice ” for field #1, select one of the following codes for this field: ERSO for ERSO-PA HSPC for Hospice MISC for Miscellaneous <hr/> If you selected “506 – Inpatient Hospital ” for field #1, select one of the following codes for this field: BS for Bariatric Surgery ERSO for ERSO-PA OOS for Out of State O for Other PAS for PAS RM for Readmission S for Surgery TNP for Transplants VNSS for Vagus Nerve Stimulator MISC for Miscellaneous <hr/> If you selected “508 – Medical ” for field #1, select one of the following codes for this field: BSS2 for Bariatric Surgery Stage 2 BTX for Botox CIERP for Cochlear Implant Exterior Replacement Parts CR for Cardiac Rehab ERSO for ERSO-PA HEA for Hearing Aids I for Infusion / Parental Therapy MC for Medications NP for Neuro-Psych OOS for Out of State PSY for Psychotherapy SYN for Synagis T for Therapies (PT/OT/ST) TX for Transportation V for Vision VST for Vest VT for Vision Therapy MISC for Miscellaneous <hr/>

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		<p>If you selected “509 – Medical Nutrition” for field #1, select one of the following codes for this field EN for Enteral Nutrition MN for Medical Nutrition MISC for Miscellaneous</p> <hr/> <p>If you selected “511 – Outpt Proc/Diag” for field #1, select one of the following codes for this field:</p> <table border="0"> <tr> <td>CCTA for Coronary CT Angiogram</td> <td>OOS for Out of State</td> </tr> <tr> <td>CI for Cochlear Implants</td> <td>OTRS for Other Surgery</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>PSCN for PET Scan</td> </tr> <tr> <td>GCK for Gamma/Cyber Knife</td> <td>O for Other</td> </tr> <tr> <td>GT for Genetic Testing</td> <td>S for Surgery</td> </tr> <tr> <td>HO for Hyperbaric Oxygen</td> <td>SCAN for Radiology</td> </tr> <tr> <td>MRI for MRI</td> <td>MISC for Miscellaneous</td> </tr> </table> <p>If you selected “513 – Physical Medicine & Rehabilitation (PM & R)” for field #1, select one of the following codes for this field: ERSO for ERSO-PA PMR for PM and R MISC for Miscellaneous</p> <p>If you selected “514 – Aging and Long Term Services Administration (LTSA)” for field #1, select one of the following codes for this field:</p> <p>PDN for Private Duty Nursing MISC for Miscellaneous</p> <hr/> <p>If you selected “518 – LTAC” for field #1, select one of the following codes for this field:</p> <p>ERSO for ERSO-PA LTAC for LTAC O for Other</p> <hr/> <p>If “519 – Respiratory” is selected for field #1, 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>	CCTA for Coronary CT Angiogram	OOS for Out of State	CI for Cochlear Implants	OTRS for Other Surgery	ERSO for ERSO-PA	PSCN for PET Scan	GCK for Gamma/Cyber Knife	O for Other	GT for Genetic Testing	S for Surgery	HO for Hyperbaric Oxygen	SCAN for Radiology	MRI for MRI	MISC for Miscellaneous	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
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ProviderOne Billing and Resource Guide

Field	Name	Action
3	Name (Required)	Enter the last name, first name, and middle initial of the client that authorization is requested for.
4	Client ID (Required)	Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): <ul style="list-style-type: none"> ▪ Contact the Agency at 1-800-562-3022 and the appropriate extension of the Authorization Unit you wish to reach (See Resources for further instructions). ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – contact the Agency either by fax or phone with the Client ID. ▪ The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where the 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 # (Required)	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI # (Required)	The 10 digit numeric 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 numeric 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 (Required)	A short description of the service requested (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA# (Required for all DME repairs)	Enter the serial number of the equipment that needs repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier (Required)	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code (Required)	Enter each service code of the item that authorization is requested for and correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested (Required)	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Provider Guides for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested (Required)	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Provider Guides and Fee Schedules for assistance) Must be entered in dollars and cents with a decimal (e.g. \$400 should be entered as 400.00).

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25	Part # (DME only) (Required for all “By Report” codes requested)	Enter the manufacturer part # of the item requested.																																																										
26	Tooth or Quad # (Required for dental requests)	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant 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. See the Place of Service Code Set (POS) code set and definitions that CMS maintains. <table border="1"> <thead> <tr> <th>Place of Service Code(s)</th> <th>Place of Service Name</th> </tr> </thead> <tbody> <tr><td>01</td><td>Pharmacy</td></tr> <tr><td>03</td><td>School</td></tr> <tr><td>04</td><td>Homeless Shelter</td></tr> <tr><td>05</td><td>Indian Health Service Free-standing Facility</td></tr> <tr><td>06</td><td>Indian Health Service Provider-based Facility</td></tr> <tr><td>07</td><td>Tribal 638 Free-standing Facility</td></tr> <tr><td>08</td><td>Tribal 638 Provider-based Facility</td></tr> <tr><td>09</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> </tbody> </table>	Place of Service Code(s)	Place of Service Name	01	Pharmacy	03	School	04	Homeless Shelter	05	Indian Health Service Free-standing Facility	06	Indian Health Service Provider-based Facility	07	Tribal 638 Free-standing Facility	08	Tribal 638 Provider-based Facility	09	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
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		49 Independent Clinic
		50 Federally Qualified Health Center (FQHC)
		51 Inpatient Psychiatric Facility
		52 Psychiatric Facility-Partial Hospitalization
		53 Community Mental Health Center
		54 Intermediate Care Facility (ICF/MR)
		55 Residential Substance Abuse Treatment Facility
		56 Psychiatric Residential Treatment Center
		57 Non-residential Substance Abuse Treatment Facility
		60 Mass Immunization Center
		61 <i>Comprehensive Inpatient Rehabilitation Facility</i>
		62 Comprehensive Outpatient Rehabilitation Facility
		65 End-Stage Renal Disease Treatment Facility
		71 Public Health Clinic
		72 Rural Health Clinic (RHC)
		81 Independent Laboratory
		99 Other Place of Service
30	Comments	Enter any free form information you consider necessary.

- A confirmation fax will be sent to the provider if the fax number can be identified by caller ID. The receiving fax must recognize the number that the fax has been sent from.
- Do not use a cover sheet when faxing an authorization request.
- The Authorization Request Form must be the first page of the fax.
- If faxing multiple requests, they must be faxed one at a time.
- If your fax machine is set to “bundle” multiple transmissions when sending to one number, please disable this function or the entire bundle of faxes will only be sent under the first cover sheet.
- If you sent paper, print out the form to send to the Agency. You can refer to your program-specific [Provider Guides](#) for policy-related questions.
- Frequently asked questions, helpful hints, and instructions for completing the authorization request form for our most common service types can be located at: <http://www.hca.wa.gov/medicaid/authorization/Pages/index.aspx>. This website contains examples of how to fill out the authorization form for specific provider types.

Pitfalls

- **Hand writing the authorization request form. Forms that are handwritten will be returned to providers.**
- **Using NPI that is not on the Agency provider file. You can confirm you are using the correct NPI by checking step 1 in your ProviderOne provider file. Please see the registration Elearning at: http://www.hca.wa.gov/medicaid/providerone/Pages/phase1/e_learning.aspx for more information about checking the provider file**
- **Using NPI for servicing provider in field instead of “pay to provider”. For the purposes of Prior Authorization, servicing NPI is referring to the billing provider.**

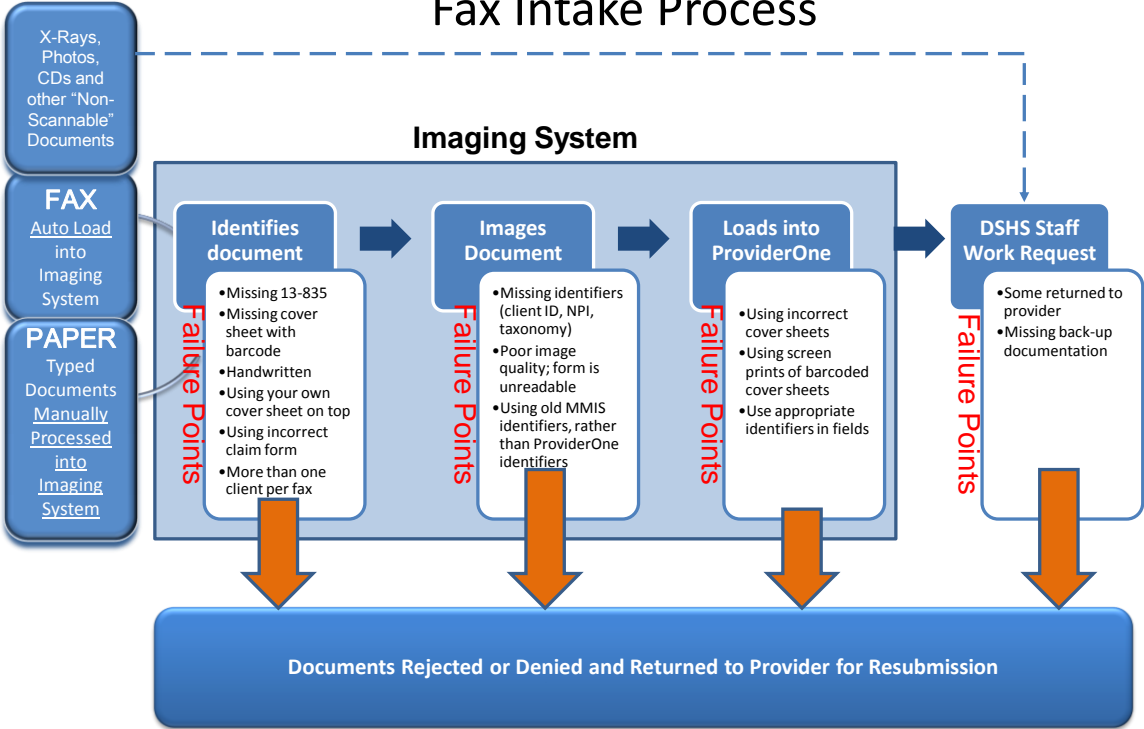
Key Step
2

Submit Authorization Request to the Agency with Required Back-up

Why

ProviderOne uses scanning technology that converts documents received via fax or paper into electronic files. Make sure the form is submitted correctly to the Agency. This will ensure your request can be processed and loaded into ProviderOne. The technology works as outlined below:

ProviderOne Paper and Fax Intake Process



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How

Prepare authorization package

By Fax

Prior authorization requests can be faxed to 1-866-668-1214. If these forms are sent correctly they can be processed and loaded into ProviderOne with less human intervention. Please follow these instructions when submitting your request:

- **Place form 13-835 as the first page that will come over the fax.**
- Please do not use your own cover sheets. The first page that comes over the fax must be HCA form 13-835.
- Set to size 8 ½ x 11 and photo quality.
- Fax each request to the Agency individually. This means pausing between each fax. If you fax multiple requests to the Agency at once, ProviderOne will group them as a single request.

By Mail

Prior Authorization requests can be mailed to:

Authorization Services Office
 PO Box 45535
 Olympia, WA 98504-5535

If sending x-rays, photos, CDs, or other non scannable items you will:

- Place the items in a large envelope;
- Attach the PA request form to the **outside** of the envelope;
- Write on the outside of the envelope:
 - Client name
 - Client ProviderOne ID
 - Your NPI
 - Your name
 - Sections the request is for:
 - MEAU (Medical)
 - DME (Durable Medical Equipment)
 - Dental or Ortho
- Then put the envelope in a larger envelope for mailing.

Another option for submitting dental photos or x-rays for Prior Authorization is the FastLook and FastAttach services provided by National Electronic Attachment, Inc. (NEA). You may register with NEA by visiting www.nea-fast.com and entering “FastWDSHS” in the blue promotion code box. Contact NEA at 800-782-5150 ext. 2 with any questions. When this option is chosen, you can fax your request to the Agency and indicate the NEA# in the NEA field on the PA Request Form.

Note: The Agency is working on a process for using a similar mechanism for medical photos.

Pitfalls

- **Using a cover sheet when faxing HCA form 13-835 to the Agency. The first page of the fax must be the Agency's authorization request form.**
- **Using automated outbound fax technology that has altered the size of the paper from 8 ½ x 11.**
- **Not having your date stamp information up to date on your fax machine.**
- **Not setting your fax machine to photo quality images.**
- **Not putting your x-rays, photos CDs in a separate envelope and not adding the required information on the outside of the inside envelope. The requests get returned to the provider if they are not submitted correctly.**

Key Step
3

Check the Status of Your Request

Why

While you are waiting for your authorization to process, you can check the status using the IVR or ProviderOne.

How

Using the IVR

To use the IVR you will need the NPI you used when you prepared the authorization request form, the ProviderOne Client ID, and date of birth. The IVR will provide the authorization number as well as the status information. Please see [Appendix A](#) for details on using the IVR to check authorization status.

You can also use ProviderOne to check the status once the authorization.

Using ProviderOne

Select “Provider Authorization Inquiry” from the provider home page.

Search by one of the following options:

- Prior Authorization Number; or
- Provider NPI AND Client ID; or
- Provider NPI, Client Last Name, Client First Name, AND Client Date of Birth

The screenshot shows a web browser window with a 'Close' and 'Submit' button at the top. Below the title bar, there is a 'PA Inquire:' header. The main content area contains the following text: 'To submit a Prior Authorization Inquiry, complete one of the following criteria sets and click "Submit".' This is followed by a bulleted list: '• Prior Authorization Number; or', '• Provider NPI AND Client ID; or', and '• Provider NPI, Client Last Name, Client First Name, AND Client Date of Birth'. Below this list, it says 'For additional information, please contact our Customer Service Center (WA State DSHS Provider Relations) (800) 562-3022'. At the bottom, there are six input fields with labels: 'Prior Authorization Number:', 'Provider NPI:', 'Client ID:', 'Client Last Name:', 'Client First Name:', and 'Client Date of Birth:'.

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If the system finds an authorization request, it will return the authorization status.

PA Utilization:

Authorization #: 100000226 Client ID: 100496975WA Service: Ambulatory Aids Request Date: 5/26/2009 Service Start Date: 5/26/2009 Requestor ID: 4578951327	Authorization Status: Requested Client Name: Organization: PA - DME Last Updated Date: 5/26/2009 Service End Date: 8/26/2009 Requestor Name:
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Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	Modifier2	Part Number	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Us
1	05/26/2009	1538333216	E1399					05/26/2009	08/26/2009	0	0	0	0	0	0



The following Authorization statuses may be returned:

Requested	This means the authorization has been requested and received.
In Review	This means your authorization is currently being reviewed.
Cancelled	This means the authorization request has been cancelled.
Pended	This means we have requested additional information from the provider in order to make a decision on the request.
Referred	This means the request has been forwarded to a second level reviewer.
Approved/Hold	This means the request has been approved, but additional information is necessary before the authorization will be released for billing.
Approved/Denied	This means the request has been partially approved and some services have been denied.
Rejected	This means the request was returned to you as incomplete.
Approved	This means the Agency has approved your request.
Denied	This means the Agency has denied your request.

Pitfalls

- Calling the Medical Assistance Customer Service Center and waiting on hold to talk with an agent to check the status of an authorization request. You can check the status without having to talk with a customer service representative.**

Key Step

4

Send in Additional Documentation if Requested by the Agency

Why

Once the Agency receives your request, it will proceed through the review process. The Agency may request additional information in order to process your request.

How

If you are mailing/faxing supporting documentation, or responding to a request from the Agency for additional information, you will need to print the Agency cover sheet. These cover sheets are needed when you fax or mail in back-up documentation to an existing authorization request. Cover Sheets can be located at:

http://www.hca.wa.gov/medicaid/billing/Pages/document_submission_cover_sheets.aspx.

There are many cover sheets that can be used for different tasks available on this website. You will want to use the “PA Pend Forms” cover sheet for submitting additional information to an existing authorization request. You will need to know the authorization number in order to use this cover sheet.

After selecting this form, you’ll be asked to fill in the PA ID. This is the authorization number. Make sure you key in the 9-digit number. Do not copy and paste the PA number into this field. Once you fill in the information, a barcode will be generated when you hit “enter” after the PA ID is entered. This bar code allows our scanner to read the number, similar to the grocery store when an item is scanned and the description and price appear on the screen of the register. Then just print the completed form, attach it to the supporting documentation, and submit either via fax (1-866-668-1214) or mail (PO Box 45535, Olympia, WA 98504-5535).

Here is an example of the PA cover sheet. You can see the authorization number entered created a complete barcode:

Cover Sheet Tips

- Hit the enter key after typing in the complete authorization number so the barcode is created. Cover sheets without completed barcodes will be returned.
- You must submit a separate cover sheet for each authorization you are submitting back-up documentation for.
- If faxing multiple documents, each cover sheet and documentation set must be faxed individually. If you fax multiple requests to the Agency at once, ProviderOne will group them as a single request and all attachments will be attached to the electronic record for the authorization identified on the first cover sheet.
- If mailing, multiple sets of documentation can be mailed in a single envelope.
- You can save the link to the cover sheets as a “Favorite,” but be sure to always get them real-time from our Web site to make sure you’re using the correct version. **Do not save these to your own desktop and re-use them.**
- Do not use a cover sheet when submitting an original prior authorization form.
- If you are creating multiple cover sheets, make sure to click “Clear Fields” before entering the next authorization number.

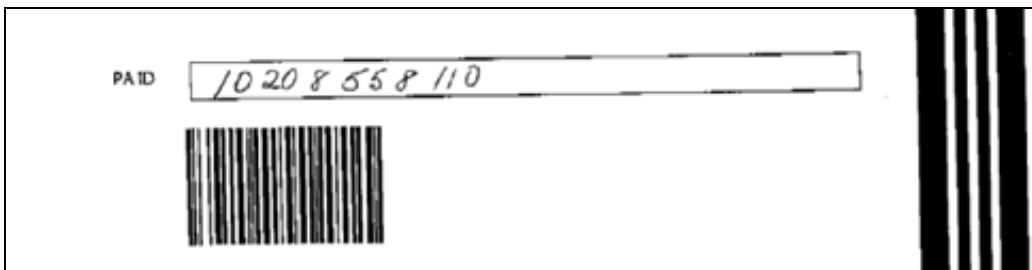
Examples of Non Scannable Cover Sheets

It is important that our new scanning technology can read the barcode on the cover sheet. If the fax quality is poor, or the barcode is incomplete, it cannot be scanned.

Here is an example of a poor quality image. The barcode below cannot be read because there are black dots all over the image. You can set your fax to “photo quality image” to improve the image quality:



This is an example of a handwritten cover sheet. You can see the barcode is incomplete. ProviderOne will not be able to read this cover sheet and attach the submitted documentation to the electronic authorization record:



Pitfalls

- **Not completing the barcode.** If you do not press enter after you type the PA ID, the barcode will not be created.
- **Using the Client ID instead of the PA ID.** You must enter the Prior Authorization number on the cover sheet.
- **Sending a cover sheet that is a poor quality image.** Barcodes must be readable by the scanner.
- **Sending an original authorization request form 13-835 when sending in additional information to attach to an existing authorization record.**

Appendix A: Use IVR to Check Status of an Authorization

Shortcut

1-800-562-3022

Key 1 + 5 + 2

How

The ProviderOne IVR accepts voice responses or **keypad entries**, indicated by brackets []. You can key ahead anytime.

Below is an overview of the prompts, see next page for detailed step-by-step instructions.

What will I hear?

The IVR will play the information only to the provider(s) identified on the authorization.

Search by the Services Card number and date of birth or by the authorization number.

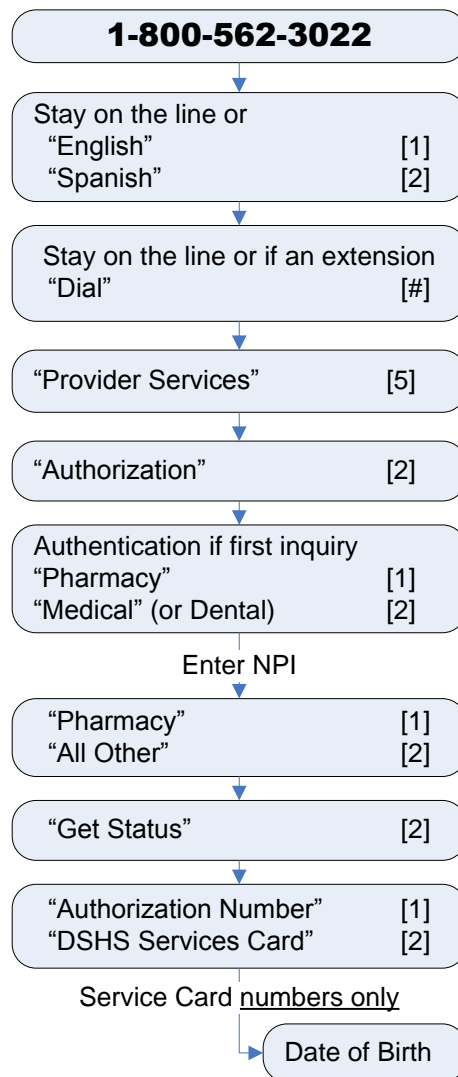
If multiple authorization numbers are found, narrow the search with an NDC or Service Code as well as an expected date of service.

The types of information available are:

- **Authorization Number**
- Status date
- Status, such as
 - Approved
 - In Review
 - Denied
 - Referred
 - Pending
 - Cancelled

Helpful Hints

- Do not say the “WA” part of the Services Card.
- Say the numbers only for the Services Code, skip the letters.
- Use your phone’s “mute” option and key choices for the fastest navigation.



Detailed Steps for Non-Pharmacy Providers

Note: The quickest navigation is using the keys on your phone

1. Dial 1-800-562-3022, the welcome message will play.
2. **Stay on the line**, don't say anything, the system is sensitive. Or, press 1 to go to the next step faster. The system will then ask about an extension.
3. **Stay on the line**. The main menu will play.
4. **Press 5** or say "Provider". The provider menu will play.
5. **Press 2** or say "Authorization". If this is the first inquiry of the call, the system needs to collect your information. The system will ask what type of provider you are.
6. **Press 2** or say "Medical". If any other type of provider, press 2. The system will ask for your NPI number.
7. **Enter the NPI** or say the NPI numbers individually. For example, if your number was 1023456, say "one", "zero", "two", etc. Do not say, "ten", "twenty-three". Saying the letter "O" is not understood for a zero. The system will then ask for the type of authorization.
8. **Press 2** or say "All Other." The system will ask what you want to do next.
9. **Press 2** or say "Get Status." Saying "submit" or pressing 1 will route the call out of the IVR. The system will next ask how you want to search for the status.
10. **Press 2** or say "Services Card, or if you have the authorization number, press 1 or say "Authorization number". The system will ask for the numbers.
11. **Enter the numbers**. If using a services card, do not say or try to enter "WA".
 - a. Enter the client's date of birth, for example 03122010.
12. If more than one authorization number is found, **enter the numbers of the service** or procedure code. Do not enter or say any letters.
13. Enter the anticipated or expected date of service.

If there are still multiple authorizations, the system will transfer you to a staff person.

The system will play the authorization number, the status and date of that status.