

# MEDICAID ALERT



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

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MA-2002-09

October 2002

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**TO:** Hospitals, Physicians, Psychologists, Mental Health Clinics, Federally Qualified Health Centers (FQHCs), Certified Nurse Practitioners/Clinical Nurse Specialists, Care Management Organizations, Non-JCAHO Accredited Psychiatric Community Residences, Mental Health Personal Care Assistance Services Providers, and JCAHO-Accredited Residential Treatment Centers, -- **For Action**  
Health Maintenance Organizations--**For Information Only**

**SUBJECT:** **Revised Completion Instructions for form FD-07A: Request for Prior Authorization Supplemental Information**

**EFFECTIVE:** Immediately

**PURPOSE:** To provide additional instructions for the completion of the form

**BACKGROUND:** In Medicaid Alert MA-2002-03, dated March 2002, providers received samples of the revised forms FD-07, Request for Prior Authorization for Mental Health and/or Mental Health Rehabilitation Services and FD-07A, Request for Prior Authorization Supplemental Information. MA 2002-03 provided guidelines for the proper completion of the forms, however the fields on the top section of the FD-07A were not addressed.

**ACTION:** All Medicaid/NJ FamilyCare-approved providers rendering mental health services, regardless of whether the service is provided to a child or an adult, are required to use forms FD-07 and FD-07A to request prior authorization for the services. This requirement has not changed; the forms have simply been revised to include the additional services. When completing the top portion of the FD-07A, providers should complete the fields as described below:

**EXCEPTION:** Programs of Assertive Community Treatment (PACT) providers are not required to complete the FD-07A. PACT providers are required to complete the FD-07 and attach a copy of the DMHS PACT Referral and Intake Outcome form and submit the forms directly to the Statewide PACT Coordinator for prior authorization of services. Please refer to Medicaid Newsletter Volume 12, No. 68, dated August 2002 for details.

**In the upper right hand corner of the form**

Enter the PA# that appears on the FD-07 onto the FD-07A. Copy the number EXACTLY as it appears on the FD-07 and file both forms together.

**Under "Provider Information"**

- Enter the provider name as registered with the Medicaid/NJ FamilyCare program
- Enter the complete billing address of the provider
- Enter the seven-digit provider number

**Under "Beneficiary Information"**

- Enter the name of the beneficiary EXACTLY as it appears on the beneficiary's Medicaid/NJ FamilyCare or Children's System of Care Initiative eligibility identification card
- Enter the 12-digit eligibility identification number EXACTLY as it appears on the beneficiary's Medicaid/NJ FamilyCare or Children's System of Care Initiative eligibility identification card

**Under "Contact Person"**

Enter the name and telephone number of a person that can be contacted by the Division if there are any questions concerning the clinical information on the form, for example, a physician or other licensed clinical professional who develops the treatment plan.

**ATTACHMENTS:**

1. An example of an FD-07A
2. Revised completion instructions for the FD-07A

**Questions?**

If you have any questions regarding prior authorization procedures, please contact the Office of Utilization Management, Mental Health Services Unit, at (609) 588-2726.

If you have any questions regarding billing procedures, please contact Unisys Provider Services at: 1-800-776-6334.

**RETAIN THIS MEDICAID ALERT CHRONOLOGICALLY BEHIND THE MEDICAID ALERTS TAB (GREEN TAB MARKED "4")**



PA # \_\_\_\_\_

STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REQUEST FOR PRIOR AUTHORIZATION  
SUPPLEMENTAL INFORMATION

**Provider Information:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Provider Identification Number

**Beneficiary Information:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Eligibility Identification Number

**Contact Person:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Telephone Number

**9a BRIEF CLINICAL HISTORY**

**10a PRESENT CLINICAL STATUS (to support request)**

**11a DIAGNOSIS AND CODE (must conform with ICD-9-CM) AND CURRENT MEDICATIONS**

**17 TREATMENT PLAN AND GOALS**

**18 ADDITIONAL CLINICAL INFORMATION (include all modifications of treatment/medication)**

**19. RESERVED FOR USE BY DMAHS CONSULTANT ONLY**

**EFFECTIVE:** September, 2001

**UPPER RIGHT CORNER OF FORM**

**DATA ELEMENT:** PA #

**Definition:** Prior authorization number on the FD-07 form (Request for Prior Authorization for Mental Health and/or Mental Health Rehabilitation Services)

**Instruction:** Enter the PA# that appears on the FD-07 onto the FD-07A. Copy the number EXACTLY as it appears on the FD-07 and file both forms together.

**Field Characteristics:**

**Values:**

**Notes:** PACT providers are required to complete the Division of Mental Health Services PACT Referral and Intake Outcome form in lieu of the FD-07A.

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**FORM: FD-07A**

**EFFECTIVE:** September, 2001

**TOP SECTION OF THE FORM**

**DATA ELEMENT:** Provider Information

**Definition:**

**Instructions:**

- Enter the provider name as registered with the Medicaid/NJ FamilyCare program
- Enter the complete billing address of the provider
- Enter the seven-digit provider number

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM: FD-07A**

**EFFECTIVE:** September, 2001

**TOP SECTION OF THE FORM**

**DATA ELEMENT:** Beneficiary Information

**Definition:**

**Instructions:**

- Enter the name of the beneficiary EXACTLY as it appears on the beneficiary's Medicaid/NJ FamilyCare or Children's System of Care Initiative eligibility identification card
- Enter the 12-digit eligibility identification number EXACTLY as it appears on the beneficiary's Medicaid/NJ FamilyCare or Children's System of Care Initiative eligibility identification card

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM: FD-07A**

**EFFECTIVE:** September, 2001

**TOP SECTION OF THE FORM**

**DATA ELEMENT:** Contact Person

**Definition:** Individual authorized to request services for the beneficiary

**Instruction:** Enter the name and telephone number of a person that can be contacted by the Division if there are any questions concerning the clinical information contained in the prior authorization request

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM: FD-07A**

**EFFECTIVE:** September, 2001

**FORM LOCATOR** 9A

**DATA ELEMENT:** Brief Clinical History

**Definition:**

**Instruction:** Enter the brief clinical history of the beneficiary. Include date and location of last treatment/hospitalization.

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM:** FD-07A

**EFFECTIVE:** September, 2001

**FORM LOCATOR** 10A

**DATA ELEMENT:** Present Clinical Status

**Definition:**

**Instruction:** Enter the current clinical status of the beneficiary.

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM:** FD-07A

**EFFECTIVE:** September, 2001

**FORM LOCATOR** 11A

**DATA ELEMENT:** Diagnosis and Code and Current Medications

**Definition:**

**Instructions:** Enter a valid and appropriate ICD-9-CM diagnosis code and a brief narrative description of the diagnosis.

List name, dose and frequency of current medications.

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM:** FD-07A

**EFFECTIVE:** September, 2001

**FORM LOCATOR** 17

**DATA ELEMENT:** Treatment Plan and Goals

**Definition:**

**Instruction:** Briefly describe the treatment plan and the goals for the beneficiary that the requested services apply to.

**Field Characteristics:**

**Values:**

**Notes:**

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**FORM:** FD-07A

**DATA ELEMENT:** Additional Clinical Information

**Definition:**

**Instruction:** Describe any modifications in the treatment and/or medications.

**Field Characteristics:**

**Values:**

**Notes:**

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**EFFECTIVE:** September, 2001

**FORM LOCATOR** 19

**DATA ELEMENT:** Reserved for use by DMAHS Consultant

**Definition:**

**Instruction:** Leave blank.

**Field Characteristics:**

**Values:**

**Notes:** All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

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**FORM: FD-07A**

## NEW JERSEY MMIS FORM REQUEST

Provider Name: \_\_\_\_\_ Provider # \_\_\_\_\_

Mailing Street Address: \_\_\_\_\_  
(Do Not Use PO Box)

IMPRINT FORMS  
(EXCEPT MC-6)  
Yes  No

City/State/Zip: \_\_\_\_\_

INSTRUCTIONS: Type or print your name, provider number, and full address above. Below, indicate the type and quantity of forms desired. Maximum order = 3 Months, please indicate number of claim forms. UNISYS will imprint **claim forms** (except MC-6) with Provider name, address and Provider number unless declined by the provider.

<u>Quantity Needed</u>	<u>Form Number</u>	<u>Form Title</u>
_____	MC-6	Prescription Claim Form
_____	*MC-9	Request for Authorization and Payment--Optical Appliances
_____	*MC-10	Dental Prior Authorization/Claim Form
_____	MC-12	Transportation Claim Form
_____	MC-19	Report and Claim Form for EPSDT/HealthStart Screening and Related Procedure

### PRIOR AUTHORIZATION FORMS

_____	MC-12(A)	Transportation Prior Authorization
_____	FD-06	Prior Authorization for Rehabilitative Services
_____	FD-07	Request for Authorization for Mental Health Services and/or Mental Health Rehabilitation Services
_____	FD-07A	Prior Authorization - Supplemental Information
_____	FD-287	Home Apnea Monitor Certification
_____	FD-352	Prior Authorization for Specialized Group Foster Home (ACCAP)
_____	FD-354	Medical Supplies and Equipment Prior Authorization
_____	FD-356	Request for Prior Authorization for Podiatric Services
_____	FD-357	Request for Prior Authorization for Prosthetic and Orthotic Services
_____	FD-358	Request for Prior Authorization for Vision Care
_____	FD-359	Request for Prior Authorization for Pharmaceutical Service
_____	FD-365	Prior Authorization Request

### Attachment Forms

_____	FD-10	Definition and Criteria for Assessing Handicapping Malocclusion Permanent Dentition
_____	FD-36	Audiologic and Hearing Aid Examinations
_____	FD-179	Physician Certification (Abortion)
_____	FD-189	Hysterectomy Receipt of Information Form
_____	FD-244	Hearing Aid Follow-Up Report
_____	FD-257	Nursing Facility Hearing Aid Screening
_____	7473-M ED	Sterilization Consent Form

### Miscellaneous Forms

_____	FD-197	Patient Certification Form
_____	FD-266	Medicaid Second Opinion Program Brochure
_____	FD-999	Adjustment Request Form-NJMMIS Medicaid
_____	FD-998	Medicaid Claim Inquiry/Response Form
_____	Reprint:	"Handicapping Malocclusion Assessment to Establish Treatment Priority"

\* These forms are a combination Prior Authorization and claim form.

***Return Completed form to: Unisys, P.O. Box 4804, Trenton, NJ 08650-4804***