Example of PAR from Home Health Agency

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY
AND FINANCING

Colorado Medicaid
Long Term Home Health
Prior Authorization Request (PAR) Form

PAR/Invoice/Agency Number

1. Client State ID Number	2. Client Name (Last, First, Middle Initial)	3. County Number	4. Sex	5. Birth Date (MM/DD/CCYY)
Y000000	Smith, John J.	16	☑ Male ☐ Female	09/13/1936

6. Service Start Date (MM/DD/CCYY)	7. Service End Date (MM/DD/CCYY)	8. Client Address (Street, City, State, ZIP Code)	9. Client Phone Number
07/16/2001	07/15/2002	222 North Street, Denver, CO 80202	(303) 555-1212

Ask the SEP for HCBS end dates - up to 1 year. Assume for this PAR = 07/15/2002.

10. Services Requested	11. Revenue Code	12. # Units Requested	13. Unit Rate	For Authorizing Agent Use Only: 14. # Units	15. Total $	16. Approved/ Pended/Denied
Nursing	551	18	71.42			
Home Health Aide - Basic Units	571	730	31.66			
Home Health Aide - Extended Units	579	1460	9.46			
Physical Therapy	421					
Occupational Therapy	431					
Speech Therapy	441					
				Total:		

17. Client's Case Status
- ☑ (1) New Admit
- ☐ (2) Ongoing
- ☐ (3) Re-Admit

18. Client's Living Arrangements
- ☑ (1) Client's Home or Home of Relative/Other Person
- ☐ (2) Alternative Care Facility
- ☐ (3) Foster Care (For Children or Adults)
- ☐ (4) Other Group Home
- ☐ (5) Other - Please Explain:

19. EPSDT Request
☐ Yes ☑ No

20. Primary Diagnosis Code from ICD-9-CM
344.1

21. Referral Codes and Discharge Codes - Check "R" before Referral Code on Admits or Re-Admits. Check "D" before Discharge Codes for Discharges - Do not use for ongoing cases

R	D		R	D		R	D		R	D	
☐	☐	(01) Alternative Care Facility	☐	☐	(08) HCBS/Developmentally Disabled	☐	☐	(14) Medicaid Home Health	☐	☐	(21) Personal Care Boarding Home
☐	☐	(02) Adult Foster Care	☐	☐	(09) HCBS/Elderly, Blind and Disabled	☐	☐	(15) Medicare Home Health	☐	☐	(22) Private Duty Nursing
☐	☐	(03) Community Centered Board	☐	☐	(10) HCBS/Mentally Ill	☐	☐	(16) Mental Health Agency	☐	☐	(23) Self/Family
☐	☐	(04) Supported Living Services	☐	☐	(11) HCBS/Persons Living With AIDS	☐	☐	(17) Moved Out of State	☐	☐	(24) Children's Medical Waiver
☐	☐	(05) Death	☐	☐	(12) Hospice	☐	☐	(19) Nursing Facility	☐	☐	(25) Children's HCBS
☐	☐	(06) Home Care Allowance	☐	☐	(13) Hospital	☐	☐	(20) Other - Explain:	☐	☐	(26) Children's Extensive Support
☐	☐	(07) HCBS/Brain Injury							☐	☑	(27) Physician

22. Primary Care Physician (PCP) Name	23. PCP Phone Number	24. PCP Provider Number
Dr. Jones	(303) 222-1234	09876543

25. Home Health Agency Name and Address	26. Home Health Agency Phone Number
Any Home Health Agency 111 R Street Denver, CO 80202	(303) 222-4321

27. Home Health Agency Signature	28. Date Signed	29. Home Health Agency Provider Number
Mary A. Agency	07/01/01	33333333

Authorizing Agency Representative Signature - Please *print* name next to Signature	SEP ID #	Date

30. Narrative statement of reason(s) for all denied unit(s)	Denials are based on the following Medicaid Regulation(s):

Form No. 01300 (05/01)

White - AUTHORIZING AGENT Yellow - ORIGINATOR