**This completed form must be attached to all wheelchair repair prior authorization (PA) requests. Portal requests are entered at (**[**http://myqualitrac.com**](http://myqualitrac.com)**). If choosing to submit the request via fax: Fax this completed form, all required documentation, and documentation of medical necessity to (866) 539-0365.**

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| **Medicaid Participant Information (skip this section if submitting request via portal)** |

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| Last Name: First Name: Initial: |
| Medicaid ID: Phone: DOB: |
| ICD-10 Diagnosis code: |

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| **Medicaid Provider Information (skip this section if submitting via Qualitrac portal)** |
| Provider Name: NPI: |
| Contact Person: Email: |
| Phone: Fax: |

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| **Wheelchair Information-required for both portal and faxed prior authorization requests.** |
| Make: Model: Hour Reading #: |
| Age of Equipment: Initial Dispense Date: |

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| **Physician Information (skip this section if submitting via Qualitrac portal)** |
| Physician Name: NPI: |

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|  | | | **Requested Equipment (skip this section if submitting request via Qualitrac Portal)** | | | | |
| **HCPCS** | **Modifier** | **Description** | | **Quantity** | **Price** **Each** | **Start Date** | **End Date** |
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| **Wheelchair Repair Information-required for both portal and faxed prior authorization requests.** |
| Is the Wheelchair within Manufacturer’s Warranty?  Yes  No |
| Name of manufacturer of replacement parts: |
| What was the initial complaint from the recipient that prompted the repair evaluation? |
| Please provide the service repair documentation from the technician describing the steps taken to determine need and what was found during the wheelchair evaluation. |
| How did the wheelchair come into disrepair? (If normal wear and tear please explain in detail the normal daily/weekly schedule of recipient’s use of this equipment.) |

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| **Required Documentation-all documentation required for both portal and faxed prior authorization requests.** |
| Current, signed and dated physician order with identification of specific equipment, diagnosis, and length of  need. (If not originally purchased by Idaho Medicaid.) |
| For items without a price listed on the fee schedule - invoice or documentation of MSRP. |
| Other documents required for specific items by Medicaid DME Supplier Provider Manual and Idaho Medicaid  DMEPOS PA Policy and medical criteria. |

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| **Medicaid Supplier Acknowledgement** |
| Supplier representative has read, agreed, and applied guidance from the most recent Idaho  DMEPOS PA Policy and Medical Criteria and Supplier Handbook.  Signed Physician’s or Non-Physician Practitioner’s order, Letter of Medical Necessity, and all required documentation is included.  Supplier understands request for services does not guarantee payment. Medicaid will not prior  authorize a service unless it is required per Idaho Medicaid Fee Schedule.  Supplier understands PA requests must be complete and valid or it will be denied due to  incomplete documentation**.** |

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| **Technician or DMA Provider Certification-required for both portal and faxed prior authorization requests.** |
| I certify that all submitted data on this form is true and accurate.  Signature: Date: |
| Printed Name: Phone Number: |

* *The status of a prior authorization request may be checked via portal or by calling (866) 538-9510.*
* *Any questions regarding this process may be sent to* [*IDMedicaidsupport@telligen.com*](mailto:IDMedicaidsupport@telligen.com)
* *More information is available at idmedicaid.telligen.com*