Supplements/Forms

Note: The most current versions of the forms listed below can be found by visiting **www.caresource.com**, click the "Provider" tab, then "Provider Materials," and then "Forms."

Table of Contents

CareSource

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Community Health

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)

hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

_____ _____
(Recipient or Representative Signature) (Date)

_____ _____
(Interpreter Signature, if required to inform the recipient of the above information) (Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

_____ _____
(Physician Signature) (Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.

MSA-2218 (Rev. 5-97) Formerly DSS-2218 which may be used

CareSource

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an_____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE

Form CMS-1696 (07/05) EF (07/05)

CareSource

Case Management Referral Form

Member Name	Medicaid ID Number	Referral Date
Member Phone Number	**PCP Name**	**Form Completed By**

Referral Reason	Check Appropriate Box(es)	Notes
Multiple Inpatient Admissions	☐	
History of Asthma, CHF, Diabetes, CKD	☐	
High Risk Pregnancy	☐	
ER Visits – 4 or more in last 6 months	☐	
BMI over 30 with Interest in Wt. Management	☐	
Complicated Medical Diagnoses	☐	
Not Receiving Needed Medical Care	☐	
Referred to Adult/Child Protective Services	☐	
Other	☐	
Additional Notes:		

Fax completed form to: 1-800-413-8260

MI-P-274

CareSource

Michigan Department of Community Health
Medical Services Administration

CERTIFICATION FOR INDUCED ABORTION

Medicaid, Adult Benefits Waiver (ABW), or MIChild payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. Although this procedure may be covered for a woman while enrolled in the ABW program, the beneficiary should also be applying for Medicaid. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure (e.g., hospital, anesthesiologist, laboratory) for billing purposes.
- Send a completed copy of the completed form with claim. (Refer to the Medicaid Provider Manual, Directory Appendix, Claim Submission/Payment.)

Any questions regarding this form should be referred to Provider Inquiry at 1-800-292-2550 or e-mail ProviderSupport@michigan.gov .

Beneficiary Name	MIhealth Number or MIChild Number	Date of Service	
Beneficiary Address (no. & street, apt./lot #, etc.)	City	State	ZIP Code

Appropriate box **must** be checked for payment to be made.

By signing below, I certify that:

☐ **the life of the mother would be endangered if the pregnancy were continued. (List the medical condition(s) that exists.)**

_____

_____

_____

_____

☐ **the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.**

In cases of rape or incest, was a police report filed?

☐ **YES** ☐ **NO** (If **NO**, explain)

If appropriate, was a report filed with the local DHS office?

☐ **YES** ☐ **NO** (If **NO**, explain)

NOTE **Payment for service is not dependent upon a report being filed with the police or the local DHS office.**

Physician Name (Type or Print)			Handwritten Signature of Physician	
Address (No. & Street, Ste., etc.)				
City	State	ZIP Code	Date Signed	Provider NPI Number

Authority: Title XIX and Title XXI of the Social Security Act.
Completion: Is Voluntary, but is required if payment from Medicaid, ABW, or MIChild program is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-4240 (09/08) Previous editions are obsolete.

CareSource

Return to CareSource by:
Fax: (937) 224-3388
Mail: P.O. Box 8730 Dayton, OH 45401-8730

Claims Recovery Request Form

(Please refer to the Provider Appeal Request Form to dispute payment)

REMITTANCE MUST BE ATTACHED

Provider Name:
National Provider Identifier (NPI):
Remittance Address *(as it appears on the EOP)***:**
Contact Person Name: **Phone Number:** ( )

Reason for Adjustment Request: Overpayment ____ Primary Insurance ____ Other _____

Total Number of Claims: _____

Check Enclosed: Yes ____ No ____ **If yes,** Check Number _____ Check Amount _____

Claim Type: Physician ____ Hospital ____ Home Health ____ Dental ____ Vision ____ Other _____

Member Name	Member ID	Begin Date of Service	End Date of Service	Claim Number	Reason for Adjustment

CareSource

Claims Recovery Request Form *(continued)*

Member Name	Member ID	Begin Date of Service	End Date of Service	Claim Number	Reason for Adjustment

CareSource

Confidential Fraud, Waste, and Abuse Reporting Form

Please use this form to tell us about any fraud, waste, and abuse concerns you may have. This information will be confidential. Give as much information as you can.

I am concerned that the following individual, who can be reached at the address and phone number listed below, is doing something fraudulent or abusive.

Name: _____
Address: _____
_____
Phone(s) _____

This person is a/an…: (please check the appropriate box)

Employee ☐ Member ☐ Provider ☐ Other* ☐

Describe your concern? Please attach additional pages, if needed.
*Please explain the relationship between the person you are reporting and CareSource or yourself.

_____
_____
_____
_____

You may remain anonymous and not tell us your name. If you don't want to remain anonymous, please give us the following information so that we may contact you if we need additional information.

Your Name: _____
Your Address: _____
_____
Your Phone No(s).: _____

If you have documents that we should review, please attach them or tell us where to find them:

To remain anonymous, send this form (and any other documents) by **mail** to**:**

CareSource
Attn: Special Investigations Unit
P.O. Box 1940
Dayton, Ohio 45401-1940

You may also submit this form by fax or e-mail. However, sending your report this way will show the number of the fax machine or your e-mail address. If you want to be anonymous, mail the form and attachments. If you do not want to be anonymous, you may send your information using these methods:

Fax: 1-800-418-0248

E-mail: fraud@caresource.com (copy the form information and attachments into the e-mail or attach them as documents).

If you have any questions, call us on the **Fraud Hotline at 1-800-390-7102, and select the appropriate menu option.**

CareSource

CONSENT FOR STERILIZATION

Michigan Department of Community Health

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____. When I first asked for the
(Doctor or Clinic)

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on_____
(Month / Day / Year)

I, _____
(Name of Individual Being Sterilized)

hereby consent of my own free will to be sterilized by

_____
(Name of Doctor and Professional Degree)

by a method called _____ .

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____ Date: _____
(Signature of Person Giving Consent) *(Month / Day / Year)*

You are requested to supply the following information, but it is not required: *Ethnicity and race designation (please check)*

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
(Interpreter's Signature) *(Month / Day / Year)*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ _____
(Signature of person obtaining consent) *(Date)*

_____
(Facility)

_____
(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ **on** _____
(Name of individual to be sterilized) *(Date of sterilization)*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended
(specify type of operation)
to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery: _____
  (describe circumstances)

_____

_____ Date: _____
(Signature of Physician and Professional Degree) *(Month / Day / Year)*

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-1959 (Rev.12-09) Previous edition may be used

CareSource

INSTRUCTIONS TO COMPLETE CONSENT FOR STERILIZATION FORM

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-1959 (Rev.12-09) Previous edition may be used

CareSource

RxAmerica
P.O. BOX 22690
Salt Lake City, UT 84122-0690
Formulary: www.Caresource.com
FAX TO: 1.866.950.5359

Coverage Determination Form

This form cannot be used to request drugs excluded from Medicare Part D, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, cough and cold, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Only one medication request per form ••• All fields must be complete and legible for review

☐ Standard Review (72 Hours)	☐ Expedited Review (24 Hours)
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain optimal function.	

Patient Information		Medication Information	
Patient Name:		Medication, Strength and Route of Administration:	
Member ID:		Quantity and Directions:	
Date of Birth:	Patient Phone Number:	Diagnosis/ICD 9:	
Patient Height/Weight/BMI:		Expected Length of Therapy:	New Prescription –OR- Date Therapy Initiated: / /
Physician Name and Specialty:		Drug Allergies: ☐ Yes ☐ No (Please List)	
Physician DEA or NPI:	Contact Person:	If injectable, is patient self-administering drug? ☐ Yes ☐ No If no, who will administer drug?	
Office Phone:	Office Fax:	If Transplant Drug: Was the transplant covered by Medicare Part A? ☐ Yes ☐ No If yes, give date:	
Pharmacy Name, Phone and Fax:		If Oral Anti-emetic: Is the drug being used as a "full replacement" of IV administration within 48 hours of cancer treatment? ☐ Yes ☐ No	

Rationale For Exception Request or Prior Authorization

NOTE: FORM CAN NOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)

☐ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy for drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s);
high risk of significant adverse clinical outcome with medication change

☐ Specify below: Anticipated significant adverse clinical outcome

☐ Medical need for different dosage form &/or higher dosage

☐ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

☐ Request for formulary tier exception
List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g. toxicity, allergy, or therapeutic failure):
(1) Drug(s) tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);
(1)_____2)_____3)_____
(1)_____2)_____3)_____
(1)_____2)_____3)_____

In order to complete the review process, chart notes documenting trial and failure on the above medication and pertinent laboratory tests and results must be included.

Prescriber's Signature:	Date:

CareSource

Interpreter Service Request Form

Request Date:_____
Name of person requesting service:_____
Contact phone #:_____

Member Information

Member Name:_____
DOB:_____
Parent's name if member is a minor:_____
Phone #:_____
CareSource ID#: _____
Member's Language/Communication mode:_____

Additional Family Members

Member Name:_____
CareSource ID# & DOB:_____
Member Name:_____
CareSource ID# & DOB:_____

Appointment Information

Date of service:_____
Time of appointment:_____
Approximate length of appointment:_____
Facility Name:_____
Office/Provider Name:_____
Address 1:_____
Address 2 (Suite #, Building#/name, etc.)_____
City, State Zip:_____
Phone #:_____
Any specific directions:_____

Completed forms can be emailed or faxed for processing:
Email – CareSourceMemberInquiry@CareSource.com
Fax – (937) 226-6916

MI-P-338

CareSource

Medicaid Managed Care
Prior Authorization Request Form

CareSource **FAX: 866-930-0019** Phone: 1-800-390-7102
Psych meds: 1-800-688-6885 X4561

Patient Information

Patient Name	DOB	Date
Patien t ID #	Sex	Medication Allergies
Pharmacy	Pharmacy Phone	

Provider Information

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

Medication Request

Drug Name	Strength	Dose	Directions (Sig)
Duration : ☐ New ☐ 3 months ☐ 6 months ☐ 9 months ☐ 1 year	Quantity	Refills	Diagnosis

Is the Patient currently treated on this medication?	☐ Yes; How Long	☐ No	
Is this a request for continuation of a previous approval?	☐ Yes	☐ No	
Has strength, dosage or quantity required per day increased or decreased?	☐ Yes	☐ No	
Does the patient have a documented allergy to the medication on the Formulary or PDL?	☐ Yes	☐ No	☐ N/A

Medical Justification/Rationale*

Please indicate previous treatment and outcomes below

Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1				
2				
3				

Previous Previous Medication(s) *

Please indicate previous treatment and outcomes below

Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1				
2				
3				

Rationale for Request/Additional Clinical Information

Provider Signature		Date
MCP Review: APPROVED / DENIED	By	Date
Authorization Number		

Attention: Has consent been given re: risks/benefits of requested medication? _____
For psych meds: Has psych eval been done? Date: _____

You must submit a copy of chart notes stating that member has tried other medication(s) before.

CareSource

Member Requested Primary Care Provider Assignments

FAX

To: PCP Change Request	From:
Fax: (937) 226-6916	Pages: (including cover page)
Phone:	Date:
Re:	CC:

Member Information: (required)

Member Name: _____

Member ID #: _____

Member Phone/Contact #: _____

Please change my Primary Care Provider to: (required)

- Provider's Name: _____
- Tax ID #: _____
- Address, City, State and Zip Code: _____
- Provider's Phone Number: _____

Member's reason for requesting the change: (required)

❑ More convenient location/hours, explain: _____

❑ Referral by family/friends: _____

❑ Dissatisfaction with doctor/staff, explain: _____

❑ Problems scheduling appointments, explain: _____

❑ I requested Dr. _____ when I enrolled through Selection Services but CareSource assigned a different doctor on my CareSource ID card.

❑ Other: _____

Other family members who should also be changed to the same provider

Member Name: _____ Member Number: _____

Member Name: _____ Member Number: _____

Member Name: _____ Member Number: _____

❑ **I want to be contacted by a CareSource representative to discuss the change**

The required fields must be completed for the change to be processed by CareSource. Members can continue to be treated by the **requested** participating Primary Care Provider until the change is complete. The member should continue to use their current ID card until the new ID card is received. PCP changes can take from 1-5 weeks to process.

Member/Member Representative Signature: _____ Date: _____

Provider (staff) Signature: (required) _____ Date: _____

November 2010

MI-P-372

CareSource

Phone: 1-800-390-7102 **Fax:** 1-888-577-5507

Michigan Provider Medical Prior Authorization Request Form

❑ Routine ❑ Urgent (72 hours)

PATIENT INFORMATION

Date of Request _____ Member ID #_____

Member's Last Name _____ First Name _____

Member Address _____

DOB _____ Phone Number _____

ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT OF PROBLEM. INCOMPLETE INFORMATION DELAYS THE DECISION PROCESS.

PROVIDER INFORMATION

Requesting Provider Name_____

Phone _____ Fax _____

Requesting Provider Address _____

Date of Service(s) Requested_____

Facility / Service Provider (First and Last Name) _____

Provider Address _____

Phone _____ Fax _____

Tax ID _____ NPI _____ DX Codes (ICD-9) _____

DX Description _____

Additional Information _____

Requested Procedures / Services / Surgery_____

Procedure Codes (CPT/HCPCS) _____

❑ **Inpatient** ❑ **Outpatient**

NUMBER OF VISITS

(Circle) 1 2 3 4 5 6 Other _____ visit(s); Refer back to PCP with report

❑ Update Authorization Number _____ # of Visits _____ Requested Extension Date_____

OTHER LIABILITY

❑ Work / Auto / Other Insurance _____

This Form Completed by: _____

THIS SECTION CARESOURCE USE ONLY

AUTHORIZATION INFORMATION

Authorization ❑ Approved ❑ Denied ❑ Pended ❑ Duplicate Request

Authorization Number_____ # of Visits / Treatments_____

Authorization To _____ From_____

Comments _____

CareSource Staff Signature_____ Date_____

The non-par SPECIALIST must have an authorization PRIOR to services rendered. Refer to CareSource "Prior Authorization" and "No Prior Authorization" lists. Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

MI-P-173 / MI-PSNP-173 August 2010

CareSource

Non-formulary Drug Prior Authorization Form

NOTE: Prior Authorization Requests without medical justification or previous medications listed will be considered INCOMPLETE. Illegible or incomplete forms will be returned.

Patient Information

Patient Name		Date
CareSource ID	DOB	Sex

Medication Request

Name of Drug			Strength	Quantity	Days Supply	
Refills	Sig.	Diagnosis	Height	Weight	BMI	HgA1C

Reason for Request

Treatment failure with formulary options (please specify):
Patient allergic to formulary alternative (please specify):
Other

Physicians Information

Prescriber Name (Print)	NPI Number	
Specialty	Phone	Fax
Mailing Address	City, State	Zip Code

Medical Justification / Include Other Medications Tried and Results

1. Previous Medication	Strength	Sig.	Duration (start / end date) and Results
2. Previous Medication	Strength	Sig.	Duration (start / end date) and Results
3. Previous Medication	Strength	Sig.	Duration (start / end date) and Results

CareSource Use Only

Authorization Denied By: (Medical Director)	Date
Authorization Number:	

230 N. Main Street, Dayton, Ohio 45402
Pharmacy Fax Number: 1-866-930-0019

MI-P-275

CareSource

Instructions for Project Claim Research Request Form

❶ Complete requestor information. Include your name, phone and fax numbers. This information is required so that CareSource may contact you about your request and that we may inform you by fax of the resolution.

❷ & ❸Complete the Servicing Provider Information. This information helps us locate the claim and ensure processing was to the correct provider.

❹ Complete Payment information. Include the name of the entity that is to be reimbursed, the Tax ID number and the payment address.

❺ Complete Member Information including the Member's Medicaid ID number. If you have multiple claims for many members, please use "Please See Attached" and attach copies of each claim in your request.

❻ Complete Claim information by providing CareSource's Claim Number from the remit. For multiple claims, please use "Please See Attached", and attach copies of your claims and/or CareSource remits.

❼ Comments. Please tell why you are sending your claim issue to be researched. Provide enough information that will help us understand the issue.

Examples:

- Claim denied for Other Carrier Information. Member has no other insurance. Please see documentation attached and investigate for other insurance.
- Removing or adding charges. Corrected claim attached.

❽ Please include the number of claims you are attaching to your request.

❾ Please fax your request to (937) 224-3388. Your request will be researched within 30 days of receipt.

Once the research has been completed, the request form will be returned to you at the fax number you provided. We will provide information on the reprocessing of your claim(s), or an explanation as to the reason the claim(s) could not be reprocessed.

At that time if you still have questions or your claim was not resolved to your satisfaction, please contact your Provider Relations Representative at (800) 390-7102 and they will be happy to assist you.

CareSource

P.O. Box 23037
Lansing, MI 48909-3037
Phone (800) 390-7102

PROVIDER CLAIM RESEARCH REQUEST FORM

Fax to: (937) 224-3388

Requestor Information: **Date:**

Name: ❶	Phone #:	Fax #:

Servicing Provider Information:

Name: ❷	Provider ID: ❸

Payment Information:

Name: ❹	Tax ID#:
Billing Address:	

Member Information:

Name: ❺	Member ID#:

Claim Information:

CareSource Claim#: ❻	Date of Service:

Please describe the claim issue below. Be sure to attach a copy of the claim, CareSource's EOP, other insurance carrier information, and any other information that will help us investigate your issue. Multiple claims for the same issue may be attached.

Comments ❼

Number of Claims included in Request: ❽

For Dayton Use:

Date Completed: _____ Completed by: _____
Comments: _____

MI-P-278

CareSource

Provider Clinical / Claim Appeal Form

Please note the following to avoid delays in processing clinical / claims appeals:

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

Please indicate the following patient information:

Member Name_____

Member ID Number_____

Date of Service_____

Code / Service not covered_____

Place of Service_____

Please indicate the following provider information:

Provider Name_____

Provider NPI Number _____

Provider Telephone Number (_____)_____

CareSource Provider ID_____

Claim Number_____

Requestor Name_____

Select the most appropriate appeal type:	Required Documentation:
❒ **Claims Appeal** — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	• **Appeal Form** • **Supporting Documentation** • **Original Remittance Advise** The provider / facility rendering services has 365 days from the date of service or date of discharge.
❒ **Clinical Appeal** — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination / non-certification decision pertaining to the same episode or care.	• **Appeal Form** • **Records supporting medical necessity** • **Original Remittance Advise** The provider / facility rendering services has 180 days from the date they are informed of the adverse determination / non-certification to request a clinical appeal.
❒ **Corrected Claim** — Any correction of the date of service, procedure / diagnosis code, incorrect unit count, location code and / or modifier to a previously processed claim. ■ Resubmit only the denied line(s) with updated information as a new claim. Please **do not** resubmit the entire claim (unless the entire claim was denied) as our system will auto deny the submission as a duplicate claim. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	STOP **Please send Corrected Claims to:** CareSource ATTN: Claims Dept. P.O. Box 1307 Dayton, OH 45401-1307

Reason for appeal request:

Mail or fax all information to:

Claims Appeals Department **P.O. Box 2008** **Dayton, OH 45401-2008**	**Clinical Appeals Department** **P.O. Box 1947** **Dayton, OH 45401-1947**	**Fax to: Provider Claims Appeal Coordinator** **Fax Number: 937-531-2398**

MI-P-150b

CareSource

PROVIDER PROFILE

THIS INFORMATION IS NEEDED BY CARESOURCE TO PROCESS CLAIMS, PRIOR AUTHORIZATIONS, AND TO MEET OUR REQUIREMENTS FOR THE STATE.

Is this a change of information about you or your billing information? ☐Yes ☐No If yes, please indicate change:

_____

Provider Name and Credentials: _____ Medicaid Provider Type: _____ ☐ Male ☐ Female

Social Security #: _____ Medical License #: _____DEA #: _____NPI:_____

Primary Specialty: _____ Secondary Specialty: _____

Board Certified? ☐Yes ☐ No Board Eligible? ☐Yes ☐ No Board Certified? ☐Yes ☐ No Board Eligible? ☐ Yes ☐No

Please provide all addresses where you will provide services to CareSource members. For each service address, please provide the corresponding Tax ID Name, Number and Billing Address. For additional addresses, please attach a second page.

1) **Primary** Practice Name: _____ Medicaid ID #:_____

Address: _____ City: _____ ZIP: _____

Phone #: _____ Fax #: _____ Federal Tax ID #: _____

Days and Hours provider is available to see members: _____

Name of entity reimbursement is to be made payable to: _____ Entity's NPI:_____

Billing Address: _____

Billing Phone #: _____ Billing Fax #: _____ Contact Person:_____

All other correspondence should be mailed to: ☐ Practice ☐ Billing ☐Other: _____

2) **Additional** Practice Name: _____ Medicaid ID #:_____

Address: _____ City: _____ ZIP: _____

Phone #: _____ Fax #: _____ Federal Tax ID #: _____

Days and Hours provider is available to see members: _____

Name of entity reimbursement is to be made payable to: _____ Entity's NPI:_____

Billing Address: _____

Billing Phone #: _____ Billing Fax #: _____ Contact Person:_____

All other correspondence should be mailed to: ☐ Practice ☐Billing ☐Other: _____

NOTE: PLEASE ATTACH A W-9 (IF DIFFERENT) FOR EACH SERVICE LOCATION.

P.O. BOX 23037, LANSING, MI 48909-3037 • 1-800-390-7102 • FAX (866) 206-2044

CSMIProviderFax@caresource.com

MARCH 2009

CareSource

Request for Reconsideration

Instructions: *Please type or print. Leave the block empty if you cannot answer it.*
Take or mail to: *Community Choice Advantage, P.O. Box 1947, Dayton, OH 45401*

1. Member Name	2. Identification Number

3. Representative Name (if applicable): ☐ Relative ☐ Attorney ☐ Other Person ☐ Provider Filing

4. **Please attach a copy of the notice(s) you received about your claim to this form.**	5. Social Security Number _____-_____-_____

6. This claim is for: ☐ Hospital ☐ Physician ☐ Skilled Nursing Facility (SNF)
☐ Emergency Room ☐ Home Health Agency (HHA) ☐ Other

7. Name of Provider (Physician, Hospital, SNF)	Provider Address, City & State
8. Date of Admission or Start of Services	9. Date(s) of the Notice(s) you received

10. I do not agree with the determination on my claim. Please reconsider my claim because:
_____
_____
_____

11. **You must obtain any evidence you wish to submit**. (Example: A letter from a doctor.) ☐ I have attached the following evidence: ☐ I will send the evidence within 10 days. ☐ I have no additional evidence or information.	12. Only one signature is needed. Signed by: ☐ Member ☐ Representative* ☐ Provider Rep **Sign Here** _____ ***If representative authorization needed**
13. Is this request filed within 60 days of your notice? ☐ Yes ☐ No If you checked "No", please attach an explanation.	14. Street Address: City, State Zip Code Phone: **Date**:

15. If this request is signed by mark (X), TWO WITNESSES who know the person requesting the reconsideration must sign in the space provided. **Witnesses are ONLY required if this request has been signed by a mark (X).**

Witness #1 _____	Witness #2 _____
Address _____	Address _____
City, State Zip _____	City, State Zip _____

DO NOT FILL IN BELOW THIS LINE, THANK YOU

16. Routing	18. Date Stamp
17. Additional Information	

H0141_MIMSNP123 CMS Approved: 11/21/2007

CareSource

SYNAGIS Prior Authorization Worksheet/Prescription Order Form.
Please FAX or MAIL this completed form to
CareSource: OH and MI Members
P.O. Box 1307, Dayton, OH 45401
Ph 1-800-488-0134 fax 1-888-752-0012

SYNAGIS®
(palivizumab)

PATIENT INFORMATION (BOLD ITEMS ARE REQUIRED)

Patient's (Child's) Name: _____ ☐ M ☐ F DOB:_____

Gestational Age (GA) ____Weeks _____Days Birth Weight _____ lb/kg Current Weight _____lb/kg Date: _____

Patient's Address: _____ Daytime Phone: (___) _____

City/State/Zip: _____ Evening Phone: (___) _____

Parent's Name:_____ Cell Phone: (___) _____ Best Time to Call:_____

Member I.D. Number: _____Other Insurance:_____

Synagis criteria are based on 2009 American Academy of Pediatrics Red Book Guidelines. **MEDICAL AUTHORIZATION CLINICAL CRITERIA** (Please check ALL that apply.)

	Infant/Child's Condition
☐	≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
☐	29 0/7 – 31 6/7 weeks GA (≤ 6 months of age at start of season) [5 dose max]
☐	32 0/7 - 34 6/7 weeks GA (<3 months of age at start of RSV season); check all risk factors that apply [3 dose max up to age 90 days]
☐	Other - Explain:

Risk Factors Consideration
- ☐ Siblings < 5 years of age
- ☐ On O_2/Airway Support
- ☐ Child Care Attendance

Day Care Name/Ph#: _____

Diagnosis for Consideration (Please Check ALL that apply.)
- ☐ Immunosuppressive/autoimmune disease
- ☐ Severe Neuromuscular Disease
- ☐ Congenital Abnormalities of Airways
- ☐ Other _____

Please note:
Risk Factors for Consideration are subject to clinical and medical review

☐ 770.7 (Please document treatment and attach supporting documentation) →

Chronic Lung Disease/BPD: Infants and children ≤ 24 months with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season.

Diagnosis: _____

Treatment:

Mechanical ventilation:	yes / no	Days/Duration _____
Supplemental oxygen:	yes / no	Days/Duration _____
Steroids and/or diuretics:	yes / no	Days/Duration _____
Other	yes / no	Days/Duration _____

☐ _____ (745–747)

Cardiac (CHD) – Hemodynamically Significant: Infants and children ≤ 24 months with hemodynamically significant cyanotic & acyanotic heart disease
- with moderate to severe pulmonary hypertension -747.83 or _____
- with cyanotic congenital heart disease -746.9 or _____
- who are receiving medication to control congestive heart failure -779.89_____ List medications:
- Other_____Dx ICD-9_____

Comments: _____

PRESCRIBER INFORMATION (REQUIRED)

Prescriber's Name: _____ Medicaid TIN #_____ DEA#_____

Practice Name:_____ NPI: _____

Address_____City_____ State_____ Zip_____

Phone_____ Fax: _____ Synagis Contact: _____

RX INFORMATION SPECIAL INSTRUCTIONS:_____

☐ **Synagis®** (palivizumab) 50 mg and/or 100 mg vials **Sig:** Inject 15 mg/kg IM one time per month _____ **# Doses**

Date for first Injection: _____ **Delivery to:** ☐ **Patient's Home** ☐ **MD Office**

Prescriber's Signature:_____ **Date:**_____