



# Prior Authorization Request Form CES Waiver

Provider Information			
Provider Name:			
Date Submitted:		Contracted (Y / N)	
Provider NPI:		Provider Tax ID (TIN):	
Provider Medicaid ID:		Provider Email Address:	
Provider Contact Name:		Provider Fax Number:	
Provider Phone:			
Provider Address:			
Member Information			
Member Name:		Member DOB:	
CareSource PASSE ID#:		Member Medicaid ID:	
Care Coordinator Name:			
PCSP Start Date:		PCSP End Date:	
ICD-10 Diagnosis Code:		Diagnosis Description:	

**INSTRUCTIONS:**

- 1.) This form should be submitted for service code(s) that require an authorization.
- 2.) Please mark the corresponding box under the heading to note the services being requested. Services are listed in the order shown below.
- 3.) Under each service category, you will find associated codes, frequency and recommended supporting documentation for submission.
- 4.) Please submit completed/signed prior authorization form and supporting documentation to the Care Coordinator's email or Care Coordination fax: 937-396-3532.
- 5.) If you are unsure of the member's Care Coordinator, please email [CareCoordination@CareSourcePASSE.com](mailto:CareCoordination@CareSourcePASSE.com).

CES Waiver	
<input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Caregiver Respite <input type="checkbox"/> Community Transition Services <input type="checkbox"/> Consultative Services <input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Environmental Modifications <input type="checkbox"/> Specialized Medical Supplies <input type="checkbox"/> Supplemental Support Services <input type="checkbox"/> Supported Employment <input type="checkbox"/> Supported Living
** Service not listed or questions about recommended clinical? Please email <a href="mailto:servicedeterminations@caresourcepasse.com">servicedeterminations@caresourcepasse.com</a>	

**By signing, I agree and acknowledge:** the listed authorizations have been reviewed and are correct for the identified CareSource PASSE member. I, as a provider of services, agree the submission of this request for Prior Authorization reflects the treatment needed for the CareSource PASSE member. I understand that this form, supporting documentation, and valid PCSP are part of the review process. Failure to actively participate in any of these processes can result in delayed authorizations.

**Please sign below.**

Your Signature (Provider Representative)	Date:
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<b>Adaptive Equipment</b>	<b>Authorization Time Period:</b> Up to 12 months or end of PCSP		<b>Limits/Guidelines:</b> See <i>Supporting Documentation</i> section		
	<b>Adaptive Equipment</b>		<b>Start Date:</b>	<b>End Date:</b>	
			<b>Care Type:</b> Elective	<b>Frequency:</b>	
	S5165 U1	Home modification; per service	<b>Cost of service</b>		<b>Total cost:</b>
	S5162	Equipment purchase	<b>Cost of service</b>		<b>Total cost:</b>
	S5161	Monthly service	<b>Cost of service</b>		<b>Total cost:</b>
	S5160	Install and testing	<b>Cost of service</b>		<b>Total cost:</b> Click to type
<b>Recommended supporting Documentation</b>		PCSP, Statement of Necessity on how equipment will support independence, Plan for how the member/family will be trained; 3 quotes / bids if item is > \$1000; Invoice			

<b>Caregiver Respite</b>	<b>Authorization Time Period:</b> Up to 12 months or end of PCSP		<b>Limits/Guidelines:</b>		The initial authorization shall not exceed 6 months or 180 days. A maximum of twelve (12) hours/day for S5151 UF and S5151 U6 UN.  More than twelve (12) hours/day can be provided for S5151 U6 and S5151 U6 UN not to exceed 15 consecutive days
	<b>CAREGIVER RESPITE SVS</b>		<b>Start Date:</b>	<b>End Date:</b>	
			<b>Care Type:</b> Elective	<b>Frequency:</b>	
	S5151 UF	1:1 (12+ hours)	<b># of hours</b>		<b>Total # units</b> (1 unit = 15 min)
	S5151 U6	Shared Staffing (12+ hr)	<b># of hours</b>		<b>Total # units</b> (1 unit = 15 min)
	S5151 UN	Shared Staffing (not overnight or more than 12 hrs)	<b># of hours</b>		<b>Total # units</b> (1 unit = 15 min)
	S5151 U6 +UN	1:1 (not overnight or more than 12 hrs)	<b># of hours</b>		<b>Total # units</b> (1 unit = 15 min)
<b>Recommended supporting Documentation</b>		PCSP, Functional assessment / areas of need, treatment plan, schedule, summary of services and family supports.			

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<b>Community Transition Svcs</b>	<b>Authorization Time Period:</b> Up to 6 months or end of PCSP		<b>Limits/Guidelines:</b>	Invoices should be submitted in advance of purchase		
	<b>Community Transition Services</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b>	Elective	<b>Frequency:</b>	
	<b>T2020</b>	<b>UA + U1</b>	<b>Total Cost</b>		<b>Total cost:</b>	
<b>Recommended supporting Documentation</b>		PCSP, HDC clinical, Itemized documentation as to how the funds requested will be used help with set-up expenses for clients transitioning from institutional setting, invoice submitted in advance of the supplies with prices (not food); provider should not buy items in advance.				

<b>Consultative Services</b>	<b>Authorization Time Period:</b> Up to 6 months or end of PCSP		<b>Limits/Guide lines:</b>	Annually cannot exceed \$1320		
	<b>CONSULTATIVE SERVICES</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b>	Elective	<b>Frequency:</b>	
	<b>T2025 UK</b>	<b>Care Planning</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>T2025 U1</b>	<b>Behavior Support</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>T2025 U3</b>	<b>Testing/Assessment</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>T2025 U4</b>	<b>Goal Training</b>	<b># of hours</b>		<b>Total hours:</b>	
<b>Recommended supporting Documentation</b>		PCSP, type of consultation, staff certification providing the consultation service, how the consultation provided will assist the member and team in carrying out goals in the PCSP				

<b>Crisis Intervention</b>	<b>Authorization Time Period:</b> up to 7 days		<b>Limits/Guidelines:</b>	PA required after exceeding 8 units per year.		
	<b>CRISIS INTERVENTION</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b>	Elective	<b>Frequency:</b>	
	<b>T2034</b>	<b>UA + U1</b>	<b>Total units:</b> (1 unit = 1 hr)			
<b>Recommended supporting Documentation</b>		PCSP to include updated crisis plan, behavior management plan and/or summary of intervention services targeting a specific area of need, additional services member receives, family and natural supports				

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<b>Environmental Mod</b>	<b>Authorization Time Period:</b> Up to end of PCSP		<b>Limits/Guidelines:</b>		Prior Authorization Required	
	<b>ENVIRONMENTAL MODIFICATIONS</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b> Elective		<b>Frequency:</b>	
	<b>K0108</b>	<b>UB</b>	<b>Total Cost:</b>			
<b>Recommended supporting Documentation:</b>		PCSP, Statement of Necessity on how support services will prevent disruption to members ability to live in the community; plan for how the member/family will be trained; 3 quotes if supports > than \$1000; invoice required				

<b>Specialized Med Sup</b>	<b>Authorization Time Period:</b> Up to the end of PCSP		<b>Limits/Guidelines:</b>		Prior Authorization Required	
	<b>SPECIALIZED MEDICAL SUPPLIES</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b> Elective		<b>Frequency:</b>	
	<b>T2028</b>		<b>Total Cost</b>		<b>Total cost:</b>	
<b>Recommended supporting Documentation</b>		PCSP, Statement of Necessity on how supplies will support independence, Plan for how the member/family will be trained, invoice				

<b>Supp Support Services</b>	<b>Authorization Time Period:</b> Up to 12 months or end of PCSP		<b>Limits/Guidelines:</b>		Prior Authorization Required	
	<b>Supplemental Support Svs</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b> Elective		<b>Frequency:</b>	
	<b>T2020</b>	<b>UA</b>	<b>Total Cost per item(s)</b>			
<b>Recommended supporting Documentation</b>		PCSP, Statement of Necessity on how support services will prevent disruption to members ability to live in the community; plan for how the member/family will be trained; 3 quotes if supports > \$1000.				

<b>Supported Employment</b>	<b>Authorization Time Period:</b> up to 6 months or end of PCSP		<b>Limits/Guidelines:</b>		Prior Authorization Required	
	<b>SUPPORTED EMPLOYMENT</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b> Elective		<b>Frequency:</b>	
	<b>H2023 U1 + UA</b>	<b>Discovery &amp; Career Planning</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>H2023 UK</b>	<b>Extended Services</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>H2023 UA + UB</b>	<b>Job Coaching 1:1</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>H2023 UQ</b>	<b>Job Coaching Shared Staffing</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>H2023 U3 + UA</b>	<b>Job Path</b>	<b># of hours</b>		<b>Total hours:</b>	
	<b>H2023 U2 + UA</b>	<b>Job Development</b>	<b># of units</b>		<b>Total # of units:</b>	
<b>Recommended supporting Documentation</b>		PCSP, Individual Career profile, Employment Plan with job goals focused on acquiring and maintaining competitive employment, progress notes				

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<b>Supportive Living</b>	<b>Authorization Time Period:</b> Up to 6 months or end of PCSP		<b>Limits/Guidelines:</b>	Prior Authorization Required; service is per diem		
	<b>SUPPORTIVE LIVING</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b>	Elective	<b>Frequency:</b>	
	H2016 UK	Enhanced Support	<b># of days</b>			
	H2016 UF	Moderate Support	<b># of days</b>			
	H2016 UH	Exceptional Support	<b># of days</b>			
	H2016 U3	Waitlist	<b># of days</b>			
<b>Recommended supporting Documentation</b>		PCSP, Functional Assessment / area of need, Schedule, Treatment Plan, Summary of additional services and family / natural supports				

<b>SL Transportation</b>	<b>Authorization Time Period:</b> Up to 6 months or end of PCSP		<b>Limits/Guidelines:</b>	PA required if exceeding 5000 miles per year		
	<b>SUPPORTIVE LIVING TRANSPORTATION</b>		<b>Start Date:</b>		<b>End Date:</b>	
			<b>Care Type:</b>	Elective	<b>Frequency:</b>	
	H2016 UD	1:1 transportation	<b># of miles</b>			
	H2016 UD + US	Multi-member Transportation	<b># of miles</b>			
<b>Recommend supporting Documentation</b>		Narrative on transportation needs to include miles; reason for transport; availability of supports closer to members residence				

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