

Instructions to fill out the General Information for Authorization form, DSHS 13-835

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1	Org (Required)	<p>ALL FIELDS MUST BE TYPED.</p> <p>Enter the Number that Matches the Program/Unit for the Request</p> <ul style="list-style-type: none"> 501 - Dental 502 - Durable Medical Equipment (DME) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 508 - Medical 509 - Medical Nutrition 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 517 – Orthodontic 518 – LTAC 519 – Respiratory 521 – Maternity Support 																																																						
2	Service Type (Required)	<p>Enter the letter(s) in all CAPS that represent the service type you are requesting.</p> <p>If you selected “501 – Dental” for field #1, please select one of the following codes for this field:</p> <table border="0" style="width: 100%;"> <tr> <td>ASC for ASC</td> <td>OUTP for Out-Patient</td> </tr> <tr> <td>CWN for Crowns</td> <td>PSM for Perio-Scaling/Maintenance</td> </tr> <tr> <td>DEN for Dentures</td> <td>PTL for Partial</td> </tr> <tr> <td>DP for Denture/Partial</td> <td>RBS for Rebases</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>RLNS for Relines</td> </tr> <tr> <td>IP for In-Patient</td> <td>MISC for Miscellaneous</td> </tr> <tr> <td>ODC for Orthodontic</td> <td></td> </tr> </table> <p>If you selected “502 – Durable Medical Equipment (DME)” for field #1, please select one of the following codes for this field:</p> <table border="0" style="width: 100%;"> <tr> <td>AA for Ambulatory Aids</td> <td>OS for Orthopedic Shoes</td> </tr> <tr> <td>BB for Bath Bench</td> <td>OTC for Orthotics</td> </tr> <tr> <td>BEM for Bath Equipment (misc.)</td> <td>OP for Ostomy Products</td> </tr> <tr> <td>BGM for Bone Growth Stimulator</td> <td>ODME for Other DME</td> </tr> <tr> <td>BP for Breast Pump</td> <td>OTRR for Other Repairs</td> </tr> <tr> <td>C for Commode</td> <td>PL for Patient Lifts</td> </tr> <tr> <td>CG for Compression Garments</td> <td>PWH for Power Wheelchair - Home</td> </tr> <tr> <td>CSC for Commode/Shower Chair</td> <td>PWNF for Power Wheelchair – NF</td> </tr> <tr> <td>DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing)</td> <td>PWR for Power Wheelchair Repair</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>PRS for Prone Standers</td> </tr> <tr> <td>FSFS for Floor Sitter/Feeder Seat</td> <td>PROS for Prosthetics</td> </tr> <tr> <td>HB for Hospital Beds</td> <td>RE for Room Equipment</td> </tr> <tr> <td>HC for Hospital Cribs</td> <td>SC for Shower Chairs</td> </tr> <tr> <td>IS for Incontinent Supplies</td> <td>SBS for Specialty “Beds/Surfaces</td> </tr> <tr> <td>MWH for Manual Wheelchair - Home</td> <td>SGD for Speech Generating Devices</td> </tr> <tr> <td>MWNF for Manual Wheelchair – NF</td> <td>SF for Standing Frames</td> </tr> <tr> <td>MWR for Manual Wheelchair Repair</td> <td>STND for Standers</td> </tr> <tr> <td></td> <td>TU TENS Units</td> </tr> <tr> <td></td> <td>US Urinary Supplies</td> </tr> <tr> <td></td> <td>WDCS VAC/Wound - decubiti supplies</td> </tr> </table>	ASC for ASC	OUTP for Out-Patient	CWN for Crowns	PSM for Perio-Scaling/Maintenance	DEN for Dentures	PTL for Partial	DP for Denture/Partial	RBS for Rebases	ERSO for ERSO-PA	RLNS for Relines	IP for In-Patient	MISC for Miscellaneous	ODC for Orthodontic		AA for Ambulatory Aids	OS for Orthopedic Shoes	BB for Bath Bench	OTC for Orthotics	BEM for Bath Equipment (misc.)	OP for Ostomy Products	BGM for Bone Growth Stimulator	ODME for Other DME	BP for Breast Pump	OTRR for Other Repairs	C for Commode	PL for Patient Lifts	CG for Compression Garments	PWH for Power Wheelchair - Home	CSC for Commode/Shower Chair	PWNF for Power Wheelchair – NF	DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing)	PWR for Power Wheelchair Repair	ERSO for ERSO-PA	PRS for Prone Standers	FSFS for Floor Sitter/Feeder Seat	PROS for Prosthetics	HB for Hospital Beds	RE for Room Equipment	HC for Hospital Cribs	SC for Shower Chairs	IS for Incontinent Supplies	SBS for Specialty “Beds/Surfaces	MWH for Manual Wheelchair - Home	SGD for Speech Generating Devices	MWNF for Manual Wheelchair – NF	SF for Standing Frames	MWR for Manual Wheelchair Repair	STND for Standers		TU TENS Units		US Urinary Supplies		WDCS VAC/Wound - decubiti supplies
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		ALL FIELDS MUST BE TYPED.
2	Service Type (Required) (Continued)	If you selected “513 – Physical Medicine & Rehabilitation (PM & R) ” for field #1, please select one of the following codes for this field: ERSO for ERSO-PA PMR for PM and R MISC for Miscellaneous
		If you selected “514 – Aging and Disability Services Administration (ADSA) ” for field #1, please select one of the following codes for this field: PDN for Private Duty Nursing MISC for Miscellaneous
		If you selected “517 – Orthodontic ” for field #1, please select one of the following codes for this field: CT for Complete ERSO for ERSO-PA IT for Interceptive Treatment LT for Limited Treatment TC for Transfer Care MISC for Miscellaneous
		If you selected “518 – LTAC ” for field #1, please select one of the following codes for this field: ERSO for ERSO-PA LTAC for LTAC O for Other
		If you selected “519 – Respiratory ” for field #1, please select one of the following codes for this field: CPAP for CPAP/Bi-Pap ERSO for ERSO-PA NEB for Nebulizer OXM for Oximeter OXY for Oxygen SUP for Supplies VENT for Vent O for Other
		If you selected “521 – Maternity Support ” for field #1, please select one of the following codes for this field: PPP for Prenatal/Post Pregnancy PO for Pregnancy Only O for Other
3	Name: (Required)	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: (Required)	Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): <ul style="list-style-type: none"> ▪ You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. ▪ The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.

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FIELD	NAME	ACTION
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: (Required)	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: (Required)	The 10 digit numeric number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: (Required) .	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: (Required) .	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: (Required) .	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: (Units or \$ required) .	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: (Units or \$ required) .	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00).
25	Part # (DME only): (Required for all "By Report" codes requested) .	Enter the manufacturer part # of the item requested.
26	Tooth or Quad#: (Required for dental requests) .	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.

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28	Diagnosis name	Short description of the diagnosis.																																																																				
29	Place of Service	Enter the appropriate two digit place of service code.																																																																				
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29	Place of Service (continued)	57	Non-residential Substance Abuse Treatment Facility
		60	Mass Immunization Center
		61	Comprehensive Inpatient Rehabilitation Facility
		62	Comprehensive Outpatient Rehabilitation Facility
		65	End-Stage Renal Disease Treatment Facility
		71	Public Health Clinic
		72	Rural Health Clinic
		81	Independent Laboratory
		99	Other Place of Service
30	Comments	Enter any free form information you deem necessary.	