Map -650
(Rev 11/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

EPSDT Special Services Home Health Fax Form

Sykes Enterprises and Health Plan Services (SHPS) Phone #: 800-292-2392 ext. 9

Date: _____ **Reviewing Nurse:** _____ **Fax #:** _____

Reference #: _____ **New Certification:** _____ **Recert:** _____ **Change:** _____

EPSDT Provider Name: _____ **Provider #:** _____

Patient Name: _____ ***Address:*** _____

County Code: _____ ***Phone ( )***_____ ***Parent/Guardian:*** _____

Medicaid #: _____ ***DOB:*** _____ ***Sex:*** _____

1. Diagnosis: _____ ***ICD-9:*** _____ ***2. Diagnosis:*** _____ ***ICD-9 :***_____

Provider Contact Name:_____***Phone:***_____

MD Name: _____

Address: _____

Phone #: ( ) _____-_____ **License #:** _____

Service(s) Requested and Location	*Procedure Code*	*# Units*	*Start Date*	*End Date*	*$ Requested*

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*Please fax completed form to SHPS at **1-502-429-5233**. If any changes/new MD orders occur before next recertification is due, please contact SHPS immediately at 1-800-292-2392 extension 9. Please submit fax form with initial request and recertifications every 60 days for PDN and 6 months for therapy.*

Patient:_____ **Medicaid #:**_____

Does the child receive other services?

_____ First Steps **Explain:** _____

_____ Other EPSDT **Explain:** _____

_____ School Services **Explain:** _____

_____ CCSHCN **Explain:** _____

_____ HCB Waiver **Explain:** _____

_____ Home Health **Explain:** _____

_____ Kidz Club **Explain:** _____

Equipment used in the home pertaining to the request (example: therapy ball, mini trampoline, nebulizer, etc.)

_____

_____

MD Appointments/ER Visits/Hospitalizations in the past 6 months:

_____

_____

Brief update/narrative of therapy or summary of patient's medications, nursing skill needs and active treatments for Private Duty Nursing:

_____

_____

_____

_____

Care Coordinator: _____ **Date:** _____
Therapist Signature: _____ **Date:** _____
Therapist Signature: _____ **Date:** _____
Therapist Signature: _____ **Date:** _____

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EPSDT Special Services Home Health Fax Form
Explanation and Instructions

The EPSDT Special Services Fax Form is used by EPSDT Special Services providers for private duty nursing services, physical therapy, occupational therapy and speech therapy preauthorizations.

The form is designed to be a complete and thorough instrument that is:
1. Utilized for the home health agency to certify that the recipient medically needs the service;
2. Utilized to document that the care coordinator and therapists have reviewed the plan of care and updated as needed;
3. Utilized to document that the service location is part of the preauthorization process;
4. Utilized by SHPS as an accessory tool to approve or deny EPSDT Special Services.

General Information

All EPSDT Special Services must be prior authorized.
It is the provider's responsibility to verify patient eligibility every month before providing the services.
When services are requested, it is important to "paint a picture" for the reviewer, so that all-relevant information about the case is presented. KCHIP Phase III children are not eligible for EPSDT Special Services-

Preauthorization is done on a case by case basis based on the medical necessity for the service.
If a preauthorization is requested, a letter with the PA number will be issued in 5-7 working days. If you have not received the letter in 5-7 working days, call SHPS back and follow-up.
Always look at your PA letter before billing the claim. Make sure the number of units, dates, codes and money amounts are correct before billing.

The time frames for authorization for services depend on the actual service:

Therapy – six months
Private Duty Nursing – two months

Important phone numbers:

SHPS – 800-292-2392
EDS Provider Enrollment – 877-838-5085
EDS Provider Relations – 800-807-1232
Medicaid EPSDT Special Services – 502-564-6890

Filling Out the Fax Form

1. Date- Enter the date fax form filled out by provider
2. Reviewing Nurse- Enter name of the SHPS Reviewing Nurse that your agency contact person spoke with about the preauthorization
3. Fax #- Enter the fax number to which your agency would like the response returned
4. Reference #- Enter SHPS's internal tracking number they assign (this is not the same number as the preauthorization number), if known
5. New Certification- Enter if a new service certification – write "yes," if not, leave blank
6. Recert- Enter if a recert write "yes," if not, leave blank
7. Change- Enter if a change occurs in the current treatment or goals and is documented with a doctor's order
8. EPSDT Provider Name- Enter your agency name
9. Provider #- Enter the EPSDT Special Services provider number
10. Contact name- Enter the name of the person from the agency who called in the review
11. Agency address- Enter the street address, city and state
12. Phone #- Enter the provider phone number
13. Patient Name- Enter the first, middle and last name of recipient
14. Address- Enter the patient address

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15. County code- Enter the patient's residence county code
16. Phone- Enter the patient's phone number
17. Parent/Guardian- Enter the name of recipient's parent or guardian
18. Medicaid #- Enter the recipient's Medicaid number - all 10 digits
19. DOB- Enter the recipient's date of birth
20. Sex- Enter the recipients' sex
21. 1. Diagnosis-Enter the primary diagnosis
22. ICD-9- Enter the ICD-9 diagnosis code
23. 2. Diagnosis- Enter the secondary diagnosis
24. ICD-9- Enter the ICD-9 diagnosis code
25. MD Name- Enter the recipient's ordering physician
26. Address- Enter the physician's address
27. Phone #- Enter the physician's phone number
28. License #- Enter the physician's license number
29. Service Requested- Enter type of service (i.e. Private Duty Nursing, PT, OT or ST)
30. Procedure Code- Enter the applicable procedure code requested, if known
31. # units- Enter the number of units requested for the services
32. Start date- Enter the first date of service for the certification/recertification period
33. End date- Enter the last date of the certification or recertification period
34. $ Requested- Enter the estimated dollar amount of each EPSDT service
35. Patient name- Enter the patient name
36. Medicaid #- Enter the 10 digit Medicaid number
37. Does the child receive other services?
    First Steps- Explain what services the child receives from First Steps
    Other EPSDT- Explain what services the child receives from EPSDT (examples: PDN, therapies)
    School Services- Explain what services the child receives from school through his IEP.
    CCSHCN- Explain what services the child receives from the Commission for Children With Special Health Care Needs
    HCB Waiver- Explain what services the child receives from Home and Community Based Waiver including Personal Care services
    Home Health- Explain what services the child receives from regular home health services
    Kidz Club- Explain what services the child receives from the Louisville based Kidz Club, if any
38. Equipment used in the home- Explain what equipment the therapist or nurse will be using in the plan of care
39. MD appts/ER Visits- Explain any visits that may be pertinent to continuing care for the child
40. Brief update- Explain all the important facts that help the reviewers decide why the child needs the services and what exactly the provider will be doing
41. Care Coordinator- Please have the person who is in charge of the case sign this line
42. Therapist Signature: Please have all the therapists involved for this request to sign this form.