



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON  
MEDICAL ADMINISTRATORS,  
INCORPORATED

272 DIA  
SR 10-XX  
04/11

INCONTINENCE PRODUCTS  
PRIOR AUTHORIZATION REQUEST FORM

\*\*\*PLEASE PRINT OR TYPE ALL INFORMATION\*\*\*

RECIPIENT NAME: \_\_\_\_\_ RECIPIENT DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_\_  
RECIPIENT MEDICAID ID: \_\_\_\_\_

PROVIDER INFORMATION

DATE OF REQUEST: \_\_\_/\_\_\_/\_\_\_\_\_  
PROVIDER NAME: \_\_\_\_\_ CONTACT PERSON #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ NH MEDICAID PROVIDER #: \_\_\_\_\_  
TELEPHONE #: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_  
FAX #: \_\_\_\_\_  
ICD-9 CODE(S): \_\_\_\_\_ ORDERING PHYSICIAN: \_\_\_\_\_  
WRITTEN DIAGNOSIS: \_\_\_\_\_

INCONTINENCE PRODUCT(S) REQUESTED

HCPC Code	Modifier	Description	Units Requested	Units Exceeding Limits (if applicable)
<b>Diapers</b>				
T4521				
T4522				
T4523				
T4524				
T4525				
T4526				
T4527				
T4528				
T4533				
T4534				
T4543				
<b>Liners</b>				
T4535				
<b>Underpads</b>				
T4541				

CERTIFICATION OF MEDICAL NECESSITY

Pursuant to He-W 571.06, to document the medical necessity for the item/service requested above, the **written** diagnosis and supporting clinical information **must be attached and included** with your request, and be **signed** by a PCP, treating physician or APRN. Pursuant to HeW 530.7, the same documentation is required for requests that exceed established quantity limits.

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

*Approval is a determination that the services requested are medically necessary and not a guarantee of payment.*

8 Commerce Drive ■ 2<sup>nd</sup> Floor ■ Bedford, NH 03110 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335