



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

INCONTINENCE PRODUCTS

PRIOR AUTHORIZATION REVISION REQUEST FORM

Purpose: This 272REV form shall be completed by incontinence providers to request a revision to an existing incontinence product prior authorization (PA) in order to provide products which better suit a recipient's needs. Permitted uses of this form are only for changes in:

- Product size that will result in a new T-code and/or modifier
- Product absorbency that will result in a new T-code and/or modifier
- Product style that will result in a new T-code and/or modifier.

A Form 272DIA prior authorization request form is required for:

- Product quantity changes
- Product type additions
- Any other purposes that would otherwise require submittal of a prior authorization request

Providers will be notified by the fiscal agent of prior authorization revisions in the same manner used for original prior authorization requests.

Provider Information

Provider Name _____ Provider ID # _____
 Contact Name _____ Title _____
 Telephone _____ Fax _____ Date _____

Recipient Information

Name _____ Medicaid ID# _____
 PA # of Prior Authorization Needing Revision _____

Product Information (use additional paper if necessary)

Indicate the change requested: SIZE ABSORBENCY STYLE

Current PA's Procedure Code & Modifier _____

Requested Procedure Code & Modifier _____

Please provide the reason for the change in product _____

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL