COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAMS

OUTPATIENT SERVICES AUTHORIZATION REQUEST
MA 97

Detailed instructions for completing the MA 97 for either prior authorization - or - 1150 Waiver are on the reverse of this sheet for your convenience as they relate to each section of the form.

When the form is completed, remove this sheet at the perforation. Then, remove the first copy of the MA 97 and send it to the appropriate address as indicated below. For those services which require a prescription, attach a copy of the Rx to the MA 97. Retain the second copy for your record.

FOR SHIFT NURSING OUTPATIENT SERVICES, SEND TO:

OUTPATIENT
PA / 1150 WAIVER SERVICES
PO BOX 8188
HARRISBURG, PA 17105-8188

FOR ALL OTHER OUTPATIENT SERVICES, SEND TO:

OUTPATIENT
PA / 1150 WAIVER SERVICES
PO BOX 8188
HARRISBURG, PA 17105-8188

PLEASE TURN TO INSTRUCTIONS ON REVERSE
GUIDELINES FOR COMPLETING THE OUTPATIENT SERVICE AUTHORIZATION REQUEST FORM (MA97)

**PATIENT INFORMATION**

- Items 1 & 2: Prior Authorization/1150 Waiver (Program Exception) (MUST, IF APPLICABLE)
  - Place a check (✓) in the appropriate box for the type of request. Check only one box per MA 97. If both types of requests are required, separate MA 97s must be completed for each type of request.

**PROVIDER/PRESCRIBER INFORMATION**

- Items 7 through 11 are to be completed using the information found on the provider's PROMIS™ Provider Enrollment Notice Information.
  - Item 7: Provider Name (MUST)
  - Item 8: Provider ID (MUST)
  - Item 9: Provider's Own Reference No. (OPTIONAL)

**REQUESTED SERVICES**

When requesting a single item or service, complete the appropriate items in Items 20A through 20G as follows:

- Item 20A: Description of Services/Supplies Requested (MUST)
  - Enter a description of the service/equipment/item, or use the DHS procedure name terminology found in the MA Program Fee Schedule. For dental services, use the appropriate CDT-4 procedure name terminology found in the MA Program Fee Schedule.

**NOTE:**

- Items 21 through 25 are available for additional requested services/equipment/items and must be completed as described in 20A through 20G. **NOTE:** FOR PRIOR AUTHORIZATION ONLY. USE ONE LINE FOR EACH MONTH BEING REQUESTED.

- Item 26A: Estimated Length of Need (No. of Months) (MUST, IF APPLICABLE)
  - If the service will be needed over a period of months, enter the # of months the recipient is expected to need the services. Enter 1-99 (99=Lifetime).

- Item 26B: Initial Date of Service (MMDDCCYY) (MUST, IF APPLICABLE)
  - Enter the date the most recent interrupted service period began. For dental services, this item is LEAVE BLANK.

- Item 26C: Beginning Date of Service For This Request (MMDDCCYY) (MUST)
  - Enter the date that the service being requested is scheduled to begin using an 8-digit format. If the service will be provided only once, enter the date the service will be provided.

- Item 27: What Other Alternatives Have Been Tried or Used to Meet This Patient’s Needs? (MUST)
  - Attach documentation, as needed, of alternatives which have been tried and justify the need for the service(s) requested - 20A through 20G. If no alternatives have been tried or used, indicate "N/A".

- Item 28: Check the Box Which Applies to This Patient’s Current Residential Status (MUST)
  - Check the appropriate box to indicate where the recipient resides.

- Item 29: Give a Narrative Description of the Specific Symptoms or Abnormalities the Service/Equipment/Supplies are Intended to Alleviate. Provide the Medical Justification Needed for the Evaluation of This Request. (MUST)
  - This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½ x 11.

- Item 30: Number of Attachments (MUST, IF APPLICABLE)
  - Indicate the number of attachments, including radiographs, that are being submitted with the MA 97.

- Item 31: Initial Request/Resubmission of Previously Denied Request (MUST, IF APPLICABLE)
  - For an initial request, enter an “X” in Item 31. If this is a resubmission of a previously denied request, enter an “X” in Item 31 and the previously denied Prior Authorization/Program Exception Reference Number from the “Prior Authorization Notice” or “Program Exception Notice” in the space provided.

- Item 32: Signature of Patient/Authorized Representative (MUST)
  - The patient or authorized representative must sign the MA 97.

- Item 33: Date (MUST)
  - The patient or authorized representative must enter the date the MA 97 was signed in 8-digit format (mmddccyy).

- Item 34: Practitioner’s/Prescriber’s Signature (MUST)
  - It is essential that the practitioner requesting the service/item sign or use his/her signature stamp on the MA 97.

- Item 35: Date (MMDDCCYY) (MUST)
  - The practitioner must enter the date the MA 97 was completed in 8-digit format.
OUTPATIENT SERVICES AUTHORIZATION REQUEST

LEAVE THIS AREA BLANK

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES OFFICE OF MEDICAL ASSISTANCE PROGRAMS

I AUTHORIZE RELEASE OF INFORMATION RELATIVE TO THIS REQUEST

SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE

DATE

PRACTITIONER / PRESCRIBER SIGNATURE

DATE

MA 97   2/15

LEAVE THIS AREA BLANK

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

OUTPATIENT SERVICES AUTHORIZATION REQUEST

1 ☐ PRIOR AUTHORIZATION

2 ☐ 1150 WAIVER (PROGRAM EXCEPTION)

PATIENT INFORMATION

3 RECIPIENT NUMBER

4 PATIENT LAST NAME

FIRST NAME

5 BIRTHDATE

6 ☐ M

☐ F

PROVIDER / PRESCRIBER INFORMATION

7 PROVIDER NAME

8 PROVIDER ID

9 PROVIDER'S OWN REFERENCE NUMBER

10 GROUP NAME

11 GROUP ID NUMBER

12 NAME OF REFERRING PRACTITIONER OR PRESCRIBER

13 LICENSE NUMBER

14 TELEPHONE NUMBER

15 PRACTITIONER'S / PRESCRIBER'S STREET ADDRESS

CITY

STATE

ZIP CODE

16 PRIMARY DIAGNOSIS

17 ICD/DSM CODE

18 SECONDARY DIAGNOSIS

19 ICD/DSM CODE

REQUESTED SERVICES

A DESCRIPTION OF SERVICES/SUPPLIES REQUESTED

FOR PRIOR AUTHORIZED SERVICES ONLY

FOR 1150 WAIVER ONLY

B PROCEDURE CODE

C MODIFIER MOD 1 MOD 2 MOD 3 MOD 4

D QUANTITY

E AMOUNT PER UNIT

F QUANTITY PER MONTH

G NUMBER OF MONTHS

H SERVICES AUTHORIZATION REQUEST

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

1150 WAIVER (PROGRAM EXCEPTION)

I ATTEST THAT IN MY PROFESSIONAL JUDGEMENT, ACTING WITHIN THE SCOPE OF MY PROFESSIONAL TRAINING AND CERTIFICATION, THAT THE PRESCRIBED SERVICE AS DEFINED ON THIS FORM IS MEDICALLY NECESSARY AND THAT THE INFORMATION PROVIDED AND STATEMENTS MADE HEREIN ARE TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

I AUTHORIZE RELEASE OF INFORMATION RELATIVE TO THIS REQUEST

SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE

DATE

PRACTITIONER / PRESCRIBER SIGNATURE

DATE

DHS COPY

OUTPATIENT SERVICES AUTHORIZATION REQUEST

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SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE

DATE

PRACTITIONER / PRESCRIBER SIGNATURE

DATE

DHS COPY