1150 ADMINISTRATIVE WAIVER REQUEST FORM

MA 325

TO BE USED FOR INPATIENT HOSPITAL SERVICES, JCAHO--CERTIFIED MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY CARE, LONG TERM CARE, AND EARLY INTERVENTION ONLY.

The 1150 Administrative Waiver Request (MA 325 form) must be completed by the prescribing physician when requesting an 1150 waiver.

Instructions for the proper completion of the form are found on the inside of this cover sheet.

(a) Read the instructions before attempting to complete the MA 325 waiver request from.

(b) Improper completion of the request form may result in a processing delay and/or rejection.

(c) Incomplete or illegible forms will be returned unprocessed.

INSTRUCTIONS FOR THE MA 325
1150 WAIVER REQUEST FORM

PRESCRIBING PRACTITIONER

The form may be used for requesting one or two items or services. Use additional forms when requesting more than two items or services; in such cases, the forms must be sent to Headquarters simultaneously.

1. When requesting a single item/service the prescribing practitioner must complete box 8A entering a name or basic description of the item/service requested and box 8B entering the number of units of the item/service requested for a specific time period. Example: 6 cases per month, must be entered in box B along with the number of months the item/service will be needed,

   If the prescribing practitioner is also the provider, boxes C and D must be completed.

   If the prescribing practitioner is not the provider, the name of the provider must be entered in box C. Also enter the provider's M.A.I.D. number, and phone number.

   Enter the provider's address in D. Enter the usual fee, if known, in box E

2. When requesting two item/services, box 9A must be completed as described in 1, above.

3. The prescriber must enter identifying information in boxes 10, 11, 12, 12A, 12B, 13A, 13B, 14, and 15.

4. The prescriber must enter primary diagnosis in box 14 with its corresponding ICD Code. If the recipient has a secondary condition or disorder, the prescriber must enter appropriate information in box 15.

5. The medical documentation should include a full description of the recipient's impairments, copies of lab reports, and diagnostic studies, medical history, current hospital discharge summaries, or any additional significant reports or documentation to support the 1150 Waiver Request.

6. The prescribing practitioner must sign and date the MA 325 form and retain the prescriber copy in his/her own files. Send the department's (DHS) copy to the appropriate address below for the type of items/service requested:

Early Intervention	Inpatient	JCAHO Certified Residential Treatment	Long Term Care
1150 Waiver Services PO Box 2675 Harrisburg, PA 17105-2675	1150 Waiver Services PO Box 8042 Harrisburg, PA 17105-8042	DHS/OMHSAS Division of Clinical Review & Consultation RTF Section PO Box 2675 Harrisburg, PA 17105-2675	1150 Waiver Services PO Box 8025 Harrisburg, PA 17105-8025

INCOMPLETE OR **ILLEGIBLE** MA 325 forms will be returned to the prescriber, unprocessed.

DEPARTMENT OF HUMAN SERVICES

The Headquarters staff reserves the right to contact other providers and to negotiate fees for items/services requested in boxes 8A and 9A.

Headquarters staff will determine if the Exception Request meets the criteria for approval.

Notice of the Department's decision will be sent to:

a. the prescribing practitioner
b. the recipient
c. the Provider(s) concerned

1150
ADMINISTRATIVE WAIVER REQUEST FORM

CONTROL NUMBER

1.

2. RECIPIENT NAME: LAST FIRST	3. RECIPIENT NUMBER	4. RES. CODE	5. SOCIAL SECURITY NUMBER - -	6. DATE OF BIRTH
7. ADDRESS				ZIP CODE

8A. ITEM/SERVICE REQUESTED	M.A.I.D. NUMBER	9A. ITEM/SERVICE REQUESTED	M.A.I.D. NUMBER
8B. QUANTITY	NUMBER OF MONTHS	9B. QUANTITY	NUMBER OF MONTHS
8C. PROVIDER NAME:		9C. PROVIDER NAME:	
8D. ADDRESS		9D. ADDRESS	
	TELEPHONE NUMBER		TELEPHONE NUMBER
8E. REQUESTED FEE $	PER MONTH $ / TOTAL $	9E. REQUESTED FEE $	PER MONTH $ / TOTAL $
8F. INDICATE HOW LONG THE ITEM/SERVICE IS REQUIRED ☐ 1 - 3 MONTHS ☐ 4 - 6 MONTHS ☐ EXTENDED PERIOD		9F. INDICATE HOW LONG THE ITEM/SERVICE IS REQUIRED ☐ 1 - 3 MONTHS ☐ 4 - 6 MONTHS ☐ EXTENDED PERIOD	
8G. INDICATE DATE ITEM/SERVICE IS TO BEGIN		9G. INDICATE DATE ITEM/SERVICE IS TO BEGIN	

10. ☐ YES ☐ NO - IS REQUEST BEING MADE AS A RESULT OF EPSDT SCREEN? (IF YES, INDICATE DATE OF SCREEN) _____ DATE

11. ☐ YES ☐ NO - IS THERE A SCHOOL MEDICAL REFERRAL FORM, PA 295, ON FILE?

12. ☐ YES ☐ NO - IS RECIPIENT IN HEALTH CARE FACILITY (IF YES INDICATE NAME OF FACILITY BELOW - IF NO IDENTIFY CARETAKER(S))?

12A. IF YES - FACILITY NAME	12B. IF NO - CARETAKER(S)		
13A. PRESCRIBER'S NAME	LICENSE NUMBER	M.A.I.D. NUMBER	MEDICAL SPECIALTY
13B. PRESCRIBER'S ADDRESS			TELEPHONE NO.
14. PRIMARY DIAGNOSIS		ICD DIAGNOSIS CODE	
15. SECONDARY DIAGNOSIS		ICD DIAGNOSIS CODE	

16. ALL OF THE FOLLOWING INFORMATION FROM THE PRESCRIBING PHYSICIAN IS ESSENTIAL IN ORDER TO ESTABLISH THE MEDICAL NECESSITY FOR THE REQUESTED ITEM/SERVICE. THE INFORMATION SUBMITTED SHOULD BE SPECIFIC TO THE REQUESTED ITEM/SERVICE.

16A. SUBMIT MEDICAL HISTORY OR COPY OF DISCHARGE SUMMARY
16B. SUBMIT COPIES OF ANY SIGNIFICANT DIAGNOSTIC STUDIES PERFORMED

_____ PRESCRIBER'S SIGNATURE

_____ DATE

WHITE – DHS COPY **YELLOW – PRESCRIBER COPY**

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ADMINISTRATIVE WAIVER REQUEST FORM

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7. ADDRESS	ZIP CODE

8A. ITEM/SERVICE REQUESTED	M.A.I.D. NUMBER
8B. QUANTITY	**NUMBER OF MONTHS**
8C. PROVIDER NAME:	
8D. ADDRESS	
	TELEPHONE NUMBER
8E. REQUESTED FEE	**PER MONTH** / **TOTAL**
$	$ / $
8F. INDICATE HOW LONG THE ITEM/SERVICE IS REQUIRED	
☐ 1 - 3 MONTHS ☐ 4 - 6 MONTHS ☐ EXTENDED PERIOD	
8G. INDICATE DATE ITEM/SERVICE IS TO BEGIN	

9A. ITEM/SERVICE REQUESTED	M.A.I.D. NUMBER
9B. QUANTITY	**NUMBER OF MONTHS**
9C. PROVIDER NAME:	
9D. ADDRESS	
	TELEPHONE NUMBER
9E. REQUESTED FEE	**PER MONTH** / **TOTAL**
$	$ / $
9F. INDICATE HOW LONG THE ITEM/SERVICE IS REQUIRED	
☐ 1 - 3 MONTHS ☐ 4 - 6 MONTHS ☐ EXTENDED PERIOD	
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13A. PRESCRIBER'S NAME	LICENSE NUMBER	M.A.I.D. NUMBER	MEDICAL SPECIALTY

13B. PRESCRIBER'S ADDRESS	TELEPHONE NO.

14. PRIMARY DIAGNOSIS	ICD DIAGNOSIS CODE
15. SECONDARY DIAGNOSIS	**ICD DIAGNOSIS CODE**

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