DEFECTIVE PRIOR AUTHORIZATION FORM
Long Term Care Administration
Department of Health Care Finance
Government of the District of Columbia

Beneficiary Name: _____ DOB: _____ Medicaid ID: _____

Address: _____ Telephone Number: _____

Authorized Representative Name: _____ ☐POA ☐HCPOA ☐Other: _____

AR Telephone: _____

Medicaid Certification Period: _____ to _____

Program Type: select one

Current Case Management Agency (CMA): Select One

CMA Provider ID: _____ Telephone Number: _____

Case Manager: _____

Case Manager Email: _____ Telephone Number: _____

Issue Description:

AFFECTED PA							
LOC Approved Date:							
Medicaid Certification Period:		**to**					
		Services Authorized	**PA#**	**Approval Period**	**Service Care Level**	**Provider ID**	**Cost Allocation**
		Select agency from drop-down					
		Provider Name	**Address**		**Phone**	**Email**	
		Select One					
		Notes:					

BELOW FOR DHCF USE ONLY

CORRECTED PA(s)							
LOC Approved Date:							
Medicaid Certification Period:		**to**					
		Services Authorized	**PA#**	**Approval Period**	**Service Care Level**	**Provider ID**	**Cost Allocation**
		Select agency from drop-down					
		Provider Name	**Address**		**Phone**	**Email**	
		Select One					

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Print Date: 09-26-2016

Beneficiary:

Medicaid ID:

Beneficiary:

Medicaid ID:

Progress Notes

For DHCF Use Only