ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

SECTION A - TO BE COMPLETED BY THE PROVIDER

☐ INITIAL ☐ RECERT ☐ MODIFICATION ☐ EXT OF BENEFITS	START DATE:	
BENEFICIARY NAME: (LAST, FIRST, MI)	BENEFICIARY MEDICAID ID #:	
BENEFICIARY MAILING ADDRESS:	DATE OF BIRTH:	SEX: ☐ MALE ☐ FEMALE
PROVIDER NAME:	PROVIDER MAILING ADDRESS:	
PROVIDER IDENTIFICATION #/TAXONOMY CODE:	PROVIDER PHONE & CONTACT PERSON:	
PRESCRIBING PHYSICIAN NAME:	PHYSICIAN PROVIDER IDENTIFICATION #/TAXONOMY CODE:	

PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS	UNITS	MSRP	POWER WHEELCHAIR GROUP (IF APPLICABLE)

I attest that the above information is true to the best of my knowledge.

_____ _____
DME PROVIDER SIGNATURE DATE

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED: _____WKS _____ MONTHS _____LIFETIME	EPSDT REFERRAL: ☐ YES ☐ NO ☐ N/A	CURRENT HEIGHT: INCHES	CURRENT WEIGHT: LBS
DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:

IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? ☐ YES ☐ NO

It is my professional opinion that the equipment requested above is medically necessary:

_____ _____
PHYSICIAN NAME (PRINT) PHYSICIAN MEDICAID ID NUMBER

_____ _____
PHYSICIAN SIGNATURE (NO STAMP) DATE

IF (PCP) PRIMARY CARE PHYSICAN IS NOT THE PRESCRIBING PHYSICIAN, THEN PLEASE PROVIDE THE FOLLOWING INFORMATION:

PRIMARY CARE PHYSICIAN (PCP) NAME (PRINT)	PCP MEDICAID ID NUMBER

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

REVIEW TYPE:	Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
DATE(S) OF SERVICE REQUESTED:	Enter the requested date(s) of service.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-digit (10-digit) Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PHYSICIAN INFORMATION:	Enter the prescribing physician's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician expects that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is made as the result of an EPSDT referral.
HEIGHT & WEIGHT:	Enter the beneficiary's current height measured in inches and weight measured in pounds.
DIAGNOSIS & ICD CODES:	In the first space, list the diagnosis & ICD code that represents the primary reason for ordering this item. List any additional diagnosis & ICD codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
PRESCRIBING PHYSICIAN:	The prescribing physician must sign/date in the space indicated. Signature and date stamps are not acceptable.
MEDICAL NECESSITY:	Documentation supporting medical necessity of the requested items must be submitted.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART A (**MUST BE COMPLETED BY DME PROVIDER ONLY**)

1. CLIENT INFORMATION:

Date:	Medicaid ID #:		Date of Birth:	
Client Name:	Sex: Male: ☐ Female: ☐		Current Height:	Current Weight:
Address:	City:	State:		Zip:

2. ACCESSIBILITY AND TRANSPORTATION:

Ramp to House:	Yes: ☐	No: ☐	School Bus:	Yes: ☐	No: ☐
Doorway Accessible:	Yes: ☐	No: ☐	Tie Down:	Yes: ☐	No: ☐
Bathroom Accessible:	Yes: ☐	No: ☐	Van Lift:	Yes: ☐	No: ☐
Equipment Fits in Trunk:	Yes: ☐	No: ☐			

If no ramp to house; describe access to house: _____

Type of vehicle: _____

Type of house:

Single-Family: ☐ Apartment: ☐ Multiplex: ☐ Mobile Home: ☐ Other: ☐

If Multi-Story, Will Client Be Required to Get Upstairs: Yes: ☐ No: ☐ N/A: ☐

If Yes, Explain: _____

_____

Is Client Enrolled in a School: Yes: ☐ No: ☐

If Yes, Name of School: _____

School Address: _____

Hours Per Day Client Spends in Wheelchair: _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART A (**MUST BE COMPLETED BY DME PROVIDER ONLY**)

3. CURRENT WHEELCHAIR AND SEATING SYSTEMS:

Has a Wheelchair: **Yes:** ☐ **No:** ☐ **Serial Number:** _____

Model/Brand Name: _____ **Manufacturer:** _____

Power: ☐ **Scooter:** ☐ **Manual:** ☐ **Standard:** ☐ **Folding:** ☐ **Rigid:** ☐

Date of Purchase: _____ **Previous DME Provider:** _____

4. PRESENT SEATING SYSTEMS:

Type of Seat: _____ **Type of Back:** _____

Seat Width: _____ **Seat Depth:** _____

Can the Current Wheelchair Be Grown/Modified/Repaired to Meet the Client's Need: **Yes:** ☐ **No:** ☐

If No, Explain: _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

PT/OT/SEATING SPECIALIST must **ONLY** complete **PART B** when requesting a Scooter, Group One or Group Two Power Wheelchairs with No Power Options

1. NEW WHEELCHAIR SPECIFICATIONS:

Power: ☐ **If Power Wheelchair, Group #:** _____ **Scooter:** ☐ **Manual:** ☐

Brand/Model Name: _____ **Manufacturer:** _____

Seat Width: _____ **Seat Depth:** _____

Seat To Floor Height: _____ **Front:** _____ **Rear:** _____

2. DRIVE CONTROLS:

Joystick:	**Yes:** ☐ **No:** ☐	**Standard Mount:**	**Swing-Away:**
Type of Joystick:	**Standard:**	**T-Bar:**	**Ball:**
Chin Control:	**Sip N' Puff:**	**Head Array:**	
Other:			
Justification:			

3. SEATING:

SEATING		
SEAT	**BACK**	**LATERAL SUPPORT**
Contour Seat:	**Contour:**	**Curved Pad:**
Custom Molded:	**Custom Molded:**	**Fixed: Left/Right**
Planar Seat:	**Folding:**	**Flat Pad:**
Size:	**Planar:**	**Swing-Away:**
Sling Seat:	**Sling Back:**	**Other:**
Solid Seat:	**Captain's Seat:**	**Justification:**
Captain's Seat:	**Other:**	
Other:	**Justification:**	
Justification:		

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

4. BASIC MEASURING AND FITTING:

Independence in a wheelchair and seating device can be either enhanced or inhibited as a result of accurate or inaccurate measurements. Make sure there are complete anatomic and equipment measurements.

ACTUAL USER MEASUREMENTS

A: _____

B (R): _____

B (L): _____

C (R): _____

C (L): _____

D1: _____

D2: _____

E (R): _____

E (L): _____

F: _____

G: _____

H: _____

I (R): _____

I (L): _____

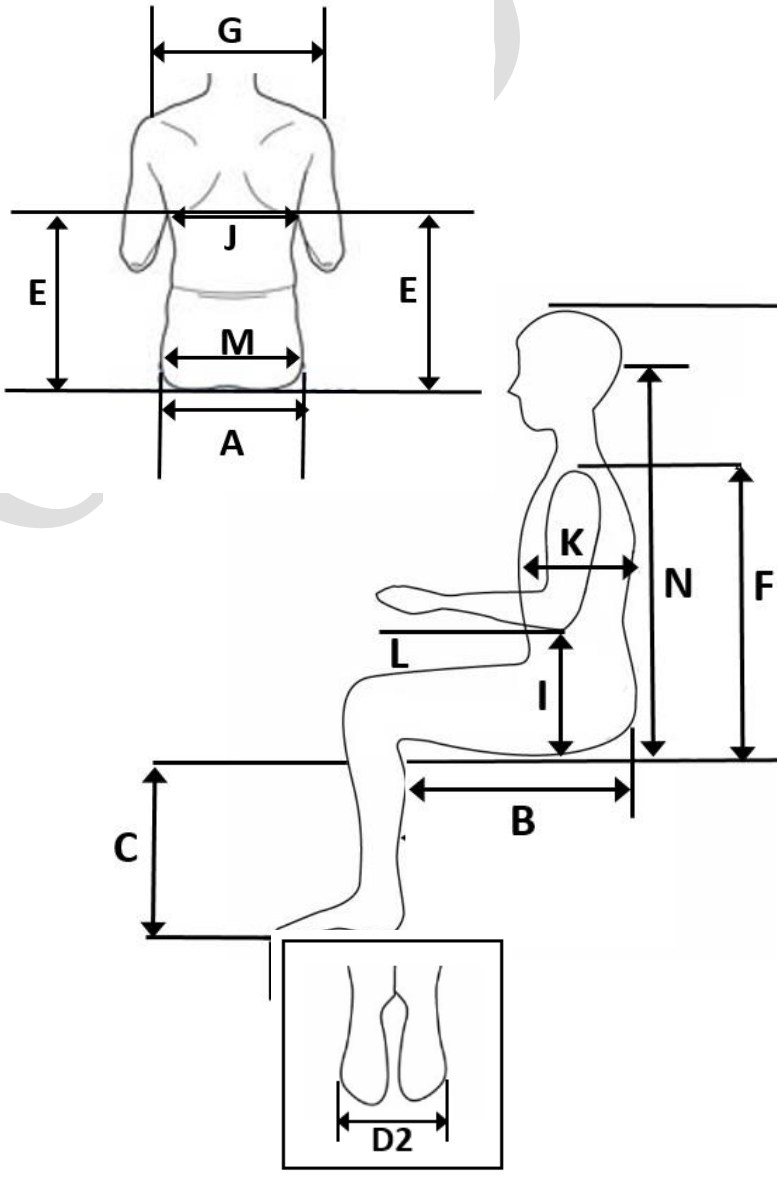
J: _____

K: _____

L: _____

M: _____

N: _____



Overall Width of Body (When Scoliosis Present)
Overall Depth of Body (When Kyphosis Present)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

5. ACCESSORIES:

ARMRESTS	FRONT RIGGING	REAR WHEELS
Adj. Height:	Angle Adjustable/High Mount:	Composite/Mag:
Arm Troughs:	Ankle Straps:	Flat Free Inserts:
Desk Length:	Articulating Leg-Rests: *(Circle Number)*	One Arm Drive:
Detachable:	60 70 75 80 85 90 Degrees	Right: Left:
Flip Back:	Detachable:	Hand-Rims *(Any Type)*:
Full Length:	Heel Loops:	Pneumatic Tires:
Padded Swing-Away:	Leg Straps:	Projection Hand-Rims:
Swing-Away:	One Piece/Platform:	Vertical/Oblique:
Other:	Shoe Holders Size:	Size:
	Swing-Away:	Spokes:
Justification:	Toe Straps:	Other:
	XLG Footplates:	
	Other:	Justification:
	Justification:	

Was Client Evaluated in a Power Wheelchair: Yes: ☐ No: ☐

If No, State Reasons Why:

If Yes, Does The Client Have The Fine Motor, Fine Sensory and Cognitive Abilities To Operate The Power Wheelchair Safely With Respect To Others? Yes: ☐ No: ☐

If No, Explain:

Additional Information:

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

6. ACCESSORIES: *(Continued)*

CASTORS:	ACCESSORIES:	SEATBELTS:
Flat-Free Inserts:	Anti-Tip Tubes:	Airplane Styles:
Pneumatic Tires:	Batteries:	Auto Styles:
Solid Tires:	Tray:	Padded:
Justification:	Type:	Velcro:
	Wheel-Lock Extensions:	Other:
	Other:	
		Justification:
	Justification:	

7. POSITIONING COMPONENTS:

Abductors: Flip Down: ☐ Removable: ☐ Fixed: ☐ Custom: ☐ Size: Detachable: ☐

Thigh Support: Left: ☐ Right: ☐ Bilateral: ☐ Fixed: ☐ Detachable: ☐

Hip Guide: Left: ☐ Right: ☐ Bilateral: ☐ Fixed: ☐ Detachable: ☐

Head/Neck Support: Type:

Vest: Chest Harness: Straps: Padded: Non-Padded:

Size: Small: Medium: Large: Extra-Large:

Anterior Trunk Support: Type: Size:

Size:

Tilt Or Recline Requirements and Justification:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

8. PHYSICAL THERAPY:

Physical Therapy: **Yes:** ☐ **No:** ☐

If Yes, Where and How Often:

Reason For Referral:

Client Lives: **Alone:** ☐ **With Spouse:** ☐ **Parents:** ☐ **Foster Parents:** ☐

Residential Facility: ☐ **Other:** ☐

If Residential Facility, Name of Facility:

Does Client Have Any of The Following: (*Check All That Apply*)

Walker: **Cane:** ☐ **Crutches:** ☐ **Braces:** ☐ **Orthotics:** ☐ **Prosthesis** ☐ **Other:** ☐ ☐

Describe How Any of The Above Are Used:

9. ENVIRONMENTAL EVALUATION:

Is Client Totally Chair Confined: **Yes:** ☐ **No:** ☐

Transfer Capabilities:

Is Client Ambulatory: **Yes:** ☐ **No:** ☐

If Yes, How Far Can Client Walk:

Please Specify Limitation:

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

10. ENVIRONMENTAL EVALUATION: *(Continued)*

a. **Is Client Able To Adequately Self-Propel in a Standard/Manual Wheelchair:** Yes: ☐ No: ☐

b. **Lightweight Wheelchair:** Yes: ☐ No: ☐

c. **Ultra-Lightweight Wheelchair:** Yes: ☐ No: ☐

d. **Any Difficulty Wheeling Over Carpet Or Grass:** Yes: ☐ No: ☐

If Yes, Explain:

e. **Type of Terrain Encountered Daily:**

11. MEDICAL NECESSITY CONSIDERATION: (Check all that apply)

a. **Independent:**	☐	**Pressure Relief:**	☐
b. **Progressive Condition:**	☐	**Endurance:**	☐
c. **Comfort:**	☐	**Growth:**	☐
d. **Supported Position:**	☐	**Other:**	☐

12. PRECAUTIONS:

Skin Breakdown: Yes: ☐ No: ☐ High Risk: ☐ Moderate Risk: ☐ Low Risk: ☐

If Yes, Describe:

Sensation: Absent: ☐ Impaired: ☐ Both: ☐

Location of Sensation:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

13. ORTHOPEDIC DEFORMITIES:

(*Check all that apply*)

Scoliosis:	☐
Kyphosis:	☐
Trunk Rotation:	☐
Pelvic Rotation:	☐
Amputee (*Specify*):	☐
Contractures:	☐
Wind Swept:	☐
Hip Dislocation:	☐
Spasms:	☐
Other:	☐

Description and Severity of Each:

TONE: *(Check all that apply)*

Hypertonic:	**Yes:** ☐	**No:** ☐
Hypotonic:	**Yes:** ☐	**No:** ☐
Mixed:	**Yes:** ☐	**No:** ☐
Normal:	**Yes:** ☐	**No:** ☐

WEAKNESS OF: *(Check All That Apply)*

All Extremities:	☐
Right Lower Extremity:	☐
Left Lower Extremity:	☐
Right Upper Extremity:	☐
Left Upper Extremity:	☐

14. SPASTICITY OF: *(Check all that apply)*

All Extremities:	☐	**Detail of Spasticity:**
Right Lower Extremity:	☐	**Detail of Spasticity:**
Left Lower Extremity:	☐	**Detail of Spasticity:**
Right Upper Extremity:	☐	**Detail of Spasticity:**
Left Upper Extremity:	☐	**Detail of Spasticity:**

Additional Details:

15. HEAD CONTROL: *(Check all that apply)*

None:	☐
Poor:	☐
Fair:	☐
Good:	☐

Provide Detail of Each:

TRUNK CONTROL: *(Check all that apply)*

None:	☐
Poor:	☐
Fair:	☐
Good:	☐

Provide Detail of Each:

PART B (MUST BE COMPLETED BY ATP ONLY)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

16. CONTRACTURES: ***(Check all that apply)*** **OTHER:** ***(Check all that apply)***

Ankles:	**Yes:**	**No:**	**Edemas:**	**Yes:**	**No:**
Hips:	**Yes:**	**No:**	**Incontinent:**	**Yes:**	**No:**
Knees:	**Yes:**	**No:**	**Poor Skin Integrity:**	**Yes:**	**No:**
Feet:	**Yes:**	**No:**	**History of Decubitus:**	**Yes:**	**No:**
Shoulders:	**Yes:**	**No:**	**Unable To Position:**	**Yes:**	**No:**
Elbows:	**Yes:**	**No:**	**Seizures:**	**Yes:**	**No:**
Hands:	**Yes:**	**No:**	**Vision:**	**Normal:**	**Impaired:**
Wrists:	**Yes:**	**No:**	**Hearing:**	**Normal:**	**Impaired:**

17. ADDITIONAL INFORMATION:

Will Client Self-Propel Manual Wheelchair Or Will Family Member Or Caregiver Push Client:

Name of ATP ***(Please Print)***

Name of PT/OT/Seating Specialist

RESNA Certified: **Yes** ☐ **No** ☐

RESNA Certification Number:

Signature of PT/OT/Seating Specialist

Signature of ATP

Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART C (MUST BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY)

1. DIAGNOSIS: CURRENT

MEDICATIONS:

1. _____ _____

_____ _____

2. _____ _____

_____ _____

3. _____ _____

_____ _____

4. _____ _____

_____ _____

5. _____ _____

_____ _____

2. INJURY:

Date of Injury: _____ **Level of Injury:** _____

Future Surgery Planned: **Yes** ☐ **No** ☐ **If Yes, Explain:** _____

_____

_____

3. MEDICAL EQUIPMENT:

Apnea Monitor: ☐ **Oxygen:** ☐ **Communication Device:** ☐

Ventilator: ☐ **Other:** ☐

4. ADDITIONAL INFORMATION: _____

_____

Seizures: **Are They Controlled?** **If Yes, How Long?** _____

_____

_____ _____

Prescribing Physician Name ***(Please Print)*** **Physician's Provider Number**

_____ _____

Prescribing Physician Signature
(No Stamp Please) **Date of Evaluation**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **May 1, 2017**

SUBJECT: **Provider Manual Update Transmittal SecV-7-16**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
DMS-679	12/14	DMS-679	5-1-17
DMS-679A	12/14	—	—
—	—	DMS-0843	5-1-17

Explanation of Updates

Section 500.000 has been updated to remove the Prescription & Prior Authorization Request for Medical Equipment form (DMS-679A), revise the Medical Equipment Request for Prior Authorization and Prescription form (DMS-679) and add the Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843).

Form DMS-679 is being updated to reflect the most current version of the form.

Form DMS-0843 is being added to all provider manuals.

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form – AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802

Form Name	Form Link
Adverse Effects Form	DMS-2704
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844
Arkansas Medicaid Patient-Centered Medical Home Program Practice Update/Change Request Form	DMS-801
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846
ARKids First Behavioral Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628

Form Name	Form Link
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Evaluation for Wheelchair and Wheelchair Seating	DMS-0843
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652

Form Name	Form Link
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Targeted Case Management Contact Monitoring Form	DMS-690
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-0843
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-801
DMS-802
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Finance Administration, Sales and Tax Use Unit
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit

Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit

Arkansas Department of Human Services, Children's Services

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, Hewlett Packard Enterprise Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation for Medical Care

Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21

Arkansas Foundation for Medical Care, Provider Relations Representative

Arkansas Hospital Association

Arkansas Office of Medicaid Inspector General (OMIG)

ARKids First-B

ARKids First-B ID Card Example

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

Dental Contractor

Hewlett Packard Enterprise Claims Department

Hewlett Packard Enterprise EDI Support Center (formerly AEVCS Help Desk)

Hewlett Packard Enterprise Inquiry Unit

Hewlett Packard Enterprise Manual Order

Hewlett Packard Enterprise Provider Assistance Center (PAC)

Hewlett Packard Enterprise Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

Select Optical

Standard Register

Table of Desirable Weights

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

SECTION V – FORMS
500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

Field Code Changed

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form – AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Field Code Changed

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802

Field Code Changed

Form Name	Form Link	
Adverse Effects Form	DMS-2704	Field Code Changed
~~AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components~~	~~DMS-679A~~	Field Code Changed
Amplification/Assistive Technology Recommendation Form	DMS-686	Field Code Changed
Application for WebRA Hardship Waiver	DMS-7736	Field Code Changed
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687	Field Code Changed
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Practice Update/Change Request Form	DMS-801	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845	Field Code Changed
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846	Field Code Changed
ARKids First Behavioral Health Services Provider Qualification Form	DMS-612	Field Code Changed
Authorization for Automatic Deposit	autodeposit	Field Code Changed
Authorization for Payment for Services Provided	MAP-8	Field Code Changed
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633	Field Code Changed
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT	Field Code Changed
Certification Statement for Abortion	DMS-2698	Field Code Changed
Change of Ownership Information	DMS-0688	Field Code Changed
Child Health Management Services Enrollment Orders	DMS-201	Field Code Changed
Child Health Management Services Discharge Notification Form	DMS-202	Field Code Changed
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A	Field Code Changed
CHMS Request for Prior Authorization	DMS-102	Field Code Changed
Claim Correction Request	DMS-2647	Field Code Changed
Consent for Release of Information	DMS-619	Field Code Changed
Contact Lens Prior Authorization Request Form	DMS-0101	Field Code Changed
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653	Field Code Changed
DDTCS Transportation Log	DMS-638	Field Code Changed
DDTCS Transportation Survey	DMS-632	Field Code Changed
Dental Treatment Additional Information	DMS-32-A	Field Code Changed
Disclosure of Significant Business Transactions	DMS-689	Field Code Changed
Disproportionate Share Questionnaire	DMS-628	Field Code Changed

Form Name	Form Link	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693	Field Code Changed
Early Childhood Special Education Referral Form	ECSE-R	Field Code Changed
EPSDT Provider Agreement	DMS-831	Field Code Changed
Evaluation for Wheelchair and Wheelchair Seating	DMS-0843	Field Code Changed
Explanation of Check Refund	HP-CR-002	Field Code Changed
Gait Analysis Full Body	DMS-647	Field Code Changed
Home Health Certification and Plan of Care	CMS-485	Field Code Changed
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645	Field Code Changed
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685	Field Code Changed
Individual Renewal Form for School-Based Audiologists	DMS-7782	Field Code Changed
Lower-Limb Prosthetic Evaluation	DMS-650	Field Code Changed
Lower-Limb Prosthetic Prescription	DMS-651	Field Code Changed
Media Selection/E-Mail Address Change Form	HP-MS-005	Field Code Changed
Medicaid Claim Inquiry Form	HP-CI-003	Field Code Changed
Medicaid Form Request	HP-MFR-001	Field Code Changed
Medical Equipment Request for Prior Authorization & Prescription	DMS-679	Field Code Changed
Medical Transportation and Personal Assistant Verification	DMS-616	Field Code Changed
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633	Field Code Changed
Notice Of Noncompliance	DMS-635	Field Code Changed
NPI Reporting Form	DMS-683	Field Code Changed
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640	Field Code Changed
Ownership and Conviction Disclosure	DMS-675	Field Code Changed
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish	Field Code Changed Field Code Changed
Practitioner Identification Number Request Form	DMS-7708	Field Code Changed
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615	Field Code Changed
Primary Care Physician Managed Care Program Referral Form	DMS-2610	Field Code Changed
Primary Care Physician Participation Agreement	DMS-2608	Field Code Changed
Primary Care Physician Selection and Change Form	DMS-2609	Field Code Changed
Procedure Code/NDC Detail Attachment Form	DMS-664	Field Code Changed
Provider Application	DMS-652	Field Code Changed

Form Name	Form Link	
Provider Communication Form	AAS-9502	Field Code Changed
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A	Field Code Changed
Provider Enrollment Application and Contract Package	Application Packet	Field Code Changed
Quarterly Monitoring Form	AAS-9506	Field Code Changed
Referral for Audiology Services – School-Based Setting	DMS-7783	Field Code Changed
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634	Field Code Changed
Referral for Medical Assistance	DMS-630	Field Code Changed
Request for Appeal	DMS-840	Field Code Changed
Request for Extension of Benefits	DMS-699	Field Code Changed
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671	Field Code Changed
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602	Field Code Changed
Request for Molecular Pathology Laboratory Services	DMS-841	Field Code Changed
Request For Orthodontic Treatment	DMS-32-0	Field Code Changed
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692	Field Code Changed
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601	Field Code Changed
Research Request Form	HP-0288	Field Code Changed
Service Log – Personal Care Delivery and Aides Notes	DMS-873	Field Code Changed
Sterilization Consent Form	DMS-615 English DMS-615 Spanish	Field Code Changed Field Code Changed
Sterilization Consent Form – Information for Men	PUB-020	Field Code Changed
Sterilization Consent Form – Information for Women	PUB-019	Field Code Changed
Targeted Case Management Contact Monitoring Form	DMS-690	Field Code Changed
Upper-Limb Prosthetic Evaluation	DMS-648	Field Code Changed
Upper-Limb Prosthetic Prescription	DMS-649	Field Code Changed
Vendor Performance Report	Vendorperformreport	Field Code Changed
Verification of Medical Services	DMS-2618	Field Code Changed

In order by form number:

AAS-9502	DMS-2618	DMS-618 Spanish	DMS-673	DMS-873
AAS-9506	DMS-2633	DMS-619	DMS-679	ECSE-R
AAS-9559	DMS-2634	DMS-628	~~DMS-679A~~	HP-0288
Address Change	DMS-2647	DMS-630	DMS-683	HP-AR-004
Autodeposit	DMS-2685	DMS-632	DMS-686	HP-CI-003
CMS-485	DMS-2687	DMS-633	DMS-689	HP-CR-002
CSPC-EPSDT	DMS-2692	DMS-635	DMS-693	HP-MFR-001
DCO-645	DMS-2698	DMS-638	DMS-699	HP-MS-005
DDS/FS#0001.a	DMS-2704	DMS-640	DMS-699A	MAP-8
DMS-0101	DMS-32-A	DMS-647	DMS-7708	Performance Report
DMS-0688	DMS-32-0	DMS-648	DMS-7736	Provider Enrollment Application and Contract Package
DMS-0843	DMS-601	DMS-649	DMS-7782	PUB-019
DMS-102	DMS-602	DMS-650	DMS-7783	PUB-020
DMS-201	DMS-612	DMS-651	DMS-801	
DMS-202	DMS-615 English	DMS-652	DMS-802	
DMS-2606	DMS-615 Spanish	DMS-652-A	DMS-831	
DMS-2608	DMS-616	DMS-653	DMS-840	
DMS-2609	DMS-618 English	DMS-664	DMS-841	
DMS-2610		DMS-671	DMS-844	
DMS-2615		DMS-675	DMS-845	
			DMS-846	

Arkansas Medicaid Contacts and Links

Click the link to view the information.

- American Hospital Association
- Americans with Disabilities Act Coordinator
- Arkansas Department of Education, Health and Nursing Services Specialist
- Arkansas Department of Education, Special Education
- Arkansas Department of Finance Administration, Sales and Tax Use Unit
- Arkansas Department of Human Services, Division of Aging and Adult Services
- Arkansas Department of Human Services, Appeals and Hearings Section
- Arkansas Department of Human Services, Division of Behavioral Health Services
- Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit

Field Code Changed

Field Code Changed

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – All Providers**

EFFECTIVE DATE: **May 1, 2017**

SUBJECT: **Provider Manual Update Transmittal SecV-7-16**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
DMS-679	12/14	DMS-679	5-1-17
DMS-679A	12/14	—	—
—	—	DMS-0843	5-1-17

Explanation of Updates

Section 500.000 has been updated to remove the Prescription & Prior Authorization Request for Medical Equipment form (DMS-679A), revise the Medical Equipment Request for Prior Authorization and Prescription form (DMS-679) and add the Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843).

Form DMS-679 is being updated to reflect the most current version of the form.

Form DMS-0843 is being added to all provider manuals.

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director