PROJECT AIDS CARE (PAC) WAIVER SERVICE AUTHORIZATION

PAC Waiver Claim Authorization Number: _ _ _ _ _ _ _ _ _

Service Provider Name: _____ **and Medicaid Number:** _____

Authorized Maximum Billable Amount per Month: $_____

Unauthorized services and services beyond the amount, duration and scope authorized by the case manager will be subject to recoupment from the service provider.

RECIPIENT INFORMATION

Recipient Name: _____ DOB: _____ Sex: ____

Address: _____ City: _____

Medicaid ID: _____ Phone #: _____

Procedure Code	Service Description	Not to exceed six months		# of Units	Per D/W/M	Maximum Amount
		From	To			
						$
						$
						$
						$

SPECIAL INSTRUCTIONS:

The above services are authorized for _____ (PAC recipient name).

_____

_____

_____

_____

_____

PRINT NAME OF CASE MANAGEMENT AGENCY:_____

PRINT NAME OF CASE MANAGER: _____ Phone: _____

SIGNATURE OF CASE MANAGER: _____ Date: _____

INSTRUCTIONS

- The Case Manager must notify providers that services have been authorized by using the PAC Waiver Service Authorization form.
- The case manager must authorize services contained in the current plan of care.
- The case manager must document the need for the service in the case narrative.
- The service provider must be qualified as per the Provider Qualifications in Chapter 1 of the PAC Waiver Services Coverage and Limitations Handbook.
- The service provider must receive a signed and completed Service Authorization form from the case manager, before providing the services.

THE FOLLOWING EXPLAINS ITEMS ON THE SERVICE AUTHORIZATION FORM.

ITEM	DESCRIPTION
■ Claim Authorization Number	The case manager's provider number. Enter in the "Referring Provider" block of the 081 claim form.
■ Service Provider Name	Name of provider.
■ Service Provider Number	Provider's PAC Medicaid Provider Number.
■ Authorized Maximum Billable	The maximum that can be reimbursed for one month.
■ Recipient Name	Recipient's name.
■ DOB	Recipient's date of birth.
■ Sex	Recipient's gender.
■ Address	Recipient's address.
■ Medicaid ID:	Recipient's Medicaid identification number.
■ Phone	Recipient's phone Number.
■ Agency Name	Case management agency name.
■ Phone	Case management agency phone number.
■ Procedure Code	PAC Waiver procedure code for service authorized.
■ Service Description	Brief description of service authorized.
■ From	Start date of service authorized.
■ To	End date of service authorized.
■ # of Units	Number of units of service authorized.
■ Per D/W/M	Frequency of authorized services delivered per day (**D**), per week (**W**) or per month (**M)**.
■ Maximum Amount	The authorized maximum billable amount for an authorized service for the duration specified on the form.
■ Special Instructions	Any special instructions, such as directions to the recipient's home, circumstances to be expected and any other helpful suggestions for the provider.