

1.1 General Submission Requirements

Member/Provider Validation

When a CMO PA request is initiated, the user is prompted to identify the specific CMO (Amerigroup, Peach State, Care Source, or Well Care) in which the member is enrolled. The member ID is validated against CMO member eligibility. In addition, the provider ID(s) is/are validated against CMO provider affiliation. If the member ID or provider ID is not associated with the CMO selected, a warning message informs the user that the member and/or provider does not appear to be associated with the selected CMO. Member enrollment validation is a 'hard edit' which prevents the provider from entering the request. Provider validation is a 'soft edit', and the provider may bypass the warning message and enter the request.

Tracking and Authorization IDs

CMO PAs submitted via the portal are assigned a 12 digit **Alliant** tracking ID that starts with "7". The requests remain in 'Pending' status until a decision is rendered by the CMOs. The CMOs are responsible for processing the PAs and submitting back to Alliant the review determinations and CMO authorization numbers. The CMO assigned authorization number is loaded to the PA on the *Provider Workspace* and displays in the 'CMO PA Request ID' field. The CMO authorization number is the number used for claims submission/adjudication.

Provider Workspace Functionality

The portal *Provider Workspace* has been customized with functions applicable to CMO PAs.

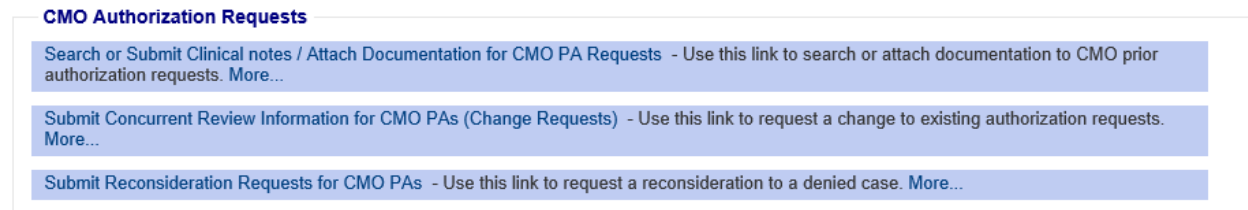


Figure 1

| FUNCTION | DESCRIPTION |
|---------------------------------|--|
| CMO PA Search | Search submitted PA's, view decisions/edits, and review PA data for CMO PA's. |
| Attach File | Attach additional clinical data to the CMO PAs form. |
| Submit Change Requests | Submit a change request with concurrent review information for inpatient admissions. |
| Submit Reconsideration Requests | Submit a reconsideration of a denied CMO PA. |

Table 2

2.0 Orthotics/Prosthetics/Hearing

The Orthotics/Prosthetics/Hearing are submitted via the *Centralized* Portal using an entry similar to submitting CMO or FFS Hospital Admission requests. The Division requires that certain services are approved to the time they are rendered. Prior approval from the division pertains to medical necessity only, not appropriateness of service. It does not guarantee payment of submitted charges, or member eligibility.

2.1 Initiate an O&P PA Request

Follow these instructions to initiate a new CMO PA request.

1. Go to the GA Web Portal at www.mmis.georgia.gov.
2. Login with assigned user ID and password.
3. On the portal secure home page, click the **Prior Authorization** tab.
4. Then click **Medical Review Portal**; Then select **Enter a New Authorization Request**.

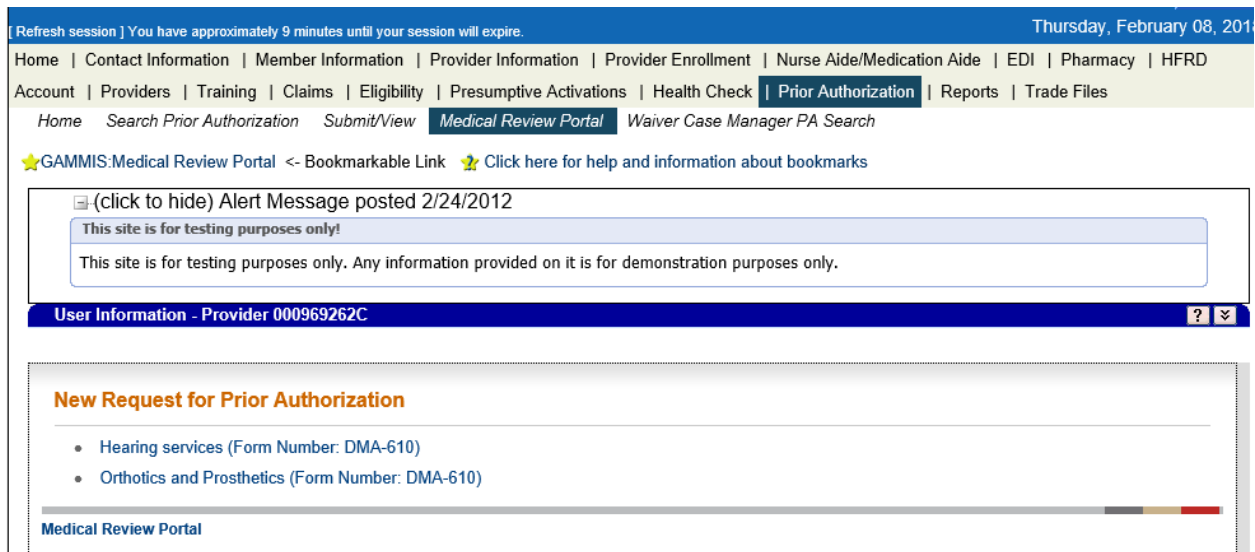


Figure 2

5. A list displays the request types applicable to the requesting provider's category of service.

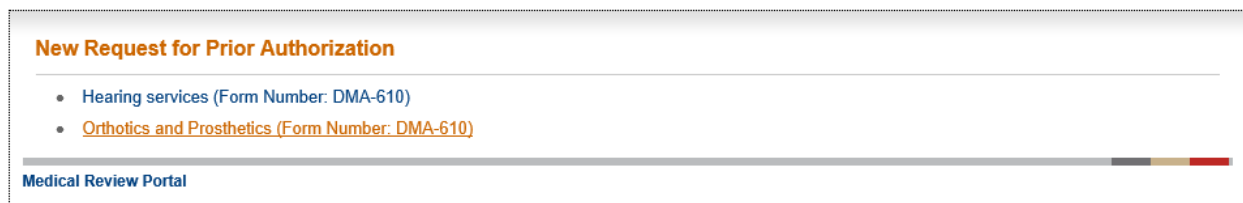


Figure 3

6. Click the request type to be entered. (O&P)

7. When the selected request type may be entered as a FFS PA or CMO PA, the user is prompted to select FFS or one of the Care Management Organizations.

New Request for Prior Authorization

Orthotics and Prosthetics (Form Number: DMA-610)

To find a Member or Provider click the next to the ID box

Select FFS or a CMO PA : Fee for Service
 Amerigroup Community Care
 CareSource Georgia Co.
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID:

Service Provider ID :

Medical Review Portal

Figure 4

8. For CMO PA entry, click the button next to the specific CMO in which the member is enrolled and enter the member's Medicaid ID number. (Note the Service Provider ID is pre-populated). Then select Submit.

New Request for Prior Authorization

Orthotics and Prosthetics (Form Number: DMA-610)

To find a Member or Provider click the next to the ID box

Select FFS or a CMO PA : Fee for Service
 Amerigroup Community Care
 CareSource Georgia Co.
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID:

Service Provider ID :


Medical Review Portal

Figure 5


9. If the member is not associated with the selected CMO, the error will be displayed.

New Request for Prior Authorization

Orthotics and Prosthetics (Form Number: DMA-610)

To find a Member or Provider click the  next to the ID box

Select FFS or a CMO PA : Fee for Service
 Amerigroup Community Care
 CareSource Georgia Co.
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID:  DESYNE J STANDFORD
Service Provider ID : RAYMOND ALDRIDGE, MD, P.C.

ERROR: Member is not enrolled in selected CMO.
Warning: All Out Of Network Providers Are Required to Submit Authorization for all Services Rendered.

Figure 6

2.2 Enter Request Information

Member and Service Provider Information is already populated based on the information selected in the previous page. (Greyed out member Medicaid ID and provider Medicaid ID)

Orthotics & Prosthetics / Hearing Services

Please verify that the member name represents the correct member for this request. If not, please select under Prior Authorization the 'Submit/View' link to re-enter the correct information. If you need assistance please select under Contact Information the 'Contact Us' link, or call the Provider Contact Center at 1-800-766-4456.

Please provide the required information for this request. When you have completed entering data for this request, select the 'Review Request' link at the bottom of the page.

Prior authorization or pre-certification does not guarantee payment, approval of service or member benefit eligibility for the service.

| Member Information | | | | | | |
|--------------------|-----------|------------|----|--------|------------|--------|
| Member ID | Last Name | First Name | MI | Suffix | DOB | Gender |
| 111111111 | STANDFORD | DESYNE | J | | 08/11/1988 | M |

| Service Provider Information | | | |
|------------------------------|---|--------------|---------------------------------------|
| Provider ID | Name and Address | Phone | Taxonomy (Specialty) |
| 000969262C | RAYMOND ALDRIDGE, MD, P.C. 3 HOSPITAL PARK MOULTRIE, GA 31768 | 229-382-5114 | - Audiologist - Audiology Services |

Figure 7

The system also populates the requesting provider's contact information in the **Contact Information** section. The 'Contact Name', 'Contact Phone', and 'Contact Fax' are required. If this information is missing, enter the information in the boxes provided. All contact information may be edited if incorrect.

| Contact Information | | | |
|---------------------|---|------------------|---|
| * Contact Name: | <input type="text" value="GMCF77"/> | * Contact Email: | <input type="text" value="susan.holmes@gmail.com"/> x |
| Contact Phone: | <input type="text" value="777-932-4456"/> Ext. <input type="text"/> | * Contact Fax: | <input type="text" value="229-386-8272"/> |

Figure 8

The **Request Information** section captures the option for providers to select the Place of Service. Users have the option to select “**Home or Other**”.

| Request Information | |
|----------------------|--|
| * Place of Service : | <input type="radio"/> Home <input type="radio"/> Other |

Figure 9

The **Diagnosis Section** table captures the diagnosis code, code description, diagnosis date, primary diagnosis indicator, and diagnosis type (ICD9 or ICD10). If the date of service is 10/1/2015 or greater, an ICD-10 diagnosis code should be used. Only one primary diagnosis may be entered although more than one admission diagnosis may be entered. Users have the option to search the diagnosis code (by selecting the magnifying glass (🔍)) or enter the diagnosis code manually. The date calendar will populate for users to select the date on the calendar or you can enter the date manually. Once the data is entered select the “**Add Button**”. This will save the data entered.

| * Diagnosis | | | | | |
|----------------------|--|----------------------|---------|--------|-------------------------------------|
| Diag Code | Diagnosis Description | Date | Primary | Type | |
| Z89.511 | ACQUIRED ABSENCE OF RIGHT LEG BELOW KNEE | 02/05/2018 | Yes | ICD-10 | <input type="button" value="EDIT"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | | | <input type="button" value="ADD"/> |

Figure 10

The **Procedure Section** table captures CPT Code, CPT code description (auto-populated), procedure ‘From Date’ and ‘To Date’, units requested, requested priced/unit, and modifiers (if applicable). The Equipment Make, Model, Manufacturer ID, and Serial No fields are all text fields which users can manually add information in these fields if applicable but are not required unless specified by CMO policy. **Prior Authorization Procedure Code Lookup Tool** is a direct link for CMO providers to use to determine if a procedure code requires a PA.

| Procedures | | | | | | | | | | | | |
|----------------------|------------------------------|----------------------|----------------------|--------------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|---------------|
| CPT Code | CPT Description | From Date | To Date | Months or Units of Service Requested | Requested Price/Unit | Mod 1 | Mod 2 | Equipment Make | Equipment Model | Manufacturer ID | Serial No | |
| L2820 | SOFT INTERFACE BELOW KNEE SE | 02/04/2018 | 03/04/2018 | 2 | 109.08 | LT | RT | | | | | EDIT |
| L2840 | TIBIAL LENGTH SOCK FX OR EQU | 02/04/2018 | 03/04/2018 | 4 | 136.88 | LT | RT | | | | | EDIT |
| L3203 | OXFORD W/ SUPINATOR/PRONATOR | 02/04/2018 | 03/04/2018 | 2 | 117.00 | LT | RT | | | | | EDIT |
| L2280 | MOLDED INNER BOOT | 02/04/2018 | 03/04/2018 | 2 | 609.82 | LT | RT | | | | | EDIT |
| L1960 | AFO POS SOLID ANK PLASTIC MO | 02/04/2018 | 03/04/2018 | 2 | 696.30 | LT | RT | | | | | EDIT |
| L2270 | VARUS/VALGUS STRAP PADDED/LI | 02/04/2018 | 03/04/2018 | 2 | 67.46 | LT | RT | | | | | EDIT |
| L2275 | PLASTIC MOD LOW EXT PAD/LINE | 02/04/2018 | 03/04/2018 | 2 | 164.14 | LT | RT | | | | | EDIT |
| <input type="text"/> | | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD CANCEL |

Figure 11

Note: Like the Diagnosis Code Section, select **Add** to add the procedure code to the request. When **Add** is selected, a blank procedure line displays, and the **Edit** button is available on the procedure line. If users need to **Edit** any previous information, select the **Edit** button and enter the corrected data, then select **Save** to store the updates.

Comments Section allows users to enter additional information that will be helpful for judgement of authorization approval. Select “**Yes**” or “**No**” if the member has retro eligibility in the table below the Comments Section.

Comments / Message

This member have retro eligibility for the submitted dates of service ? Yes No

Figure 12

Repairs and Replacements section should be completed if priced amount is over \$250.00. The Manufacturer ID, Serial No, Warranty Registration Number, Date of Original Purchase, and Manufacturer Warranty Duration (in months) are needed.

| For Repairs / Replacements over \$200.00 | | | | | |
|--|----------------------|------------------------------|---------------------------|--|------------------------------------|
| Manufacturer ID | Serial No | Warranty Registration Number | Date of Original Purchase | Manufacturer Warranty Duration (In Months) | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="button" value="ADD"/> |

Figure 13

Therapist/Other Service Provider Justification Information section captures the following required information: member’s height and weight, and information related to the physician prescription for services. Therapist information and justification for services may be provided but is optional. Lastly, answer “**Yes**” or “**No**” if a signed physician’s prescription or Certificate of Medical Necessity is on file within 90 days of request. Then Select **Review Request** when all data is entered on this form.

| Therapist Information | | | Patient Information | |
|---|--|--------------------------------|--|---------------------------|
| * Therapist / Other Service Provider Name : | * Georgia License / Certification Number : | * Certification Type : | Patient Height (inches) : | Patient Weight (pounds) : |
| <input type="text"/> | <input type="text"/> | <input type="text" value="v"/> | <input type="text"/> in. | <input type="text"/> lb. |
| Justification and Circumstances for Requested Services : | | | | |
| Describe why the patient needs O/P, medical justification for services requested. | | | | |
| <input type="text"/> | | | | |
| Was a signed physician's prescription or Certificate of Medical Necessity on file within 90 days of request ? | | | <input type="radio"/> Yes <input type="radio"/> No | |
| <input type="button" value="Review Request"/> | | | | |

2.3 Additional Questions Form

Additional Questions Form is populated based on the procedure code(s) that are being requested: The forms are related to Foot and Ankle Orthotics, Knee Orthotics, Wrist Orthotics, and Diabetic Shoes. Input in these fields are required. See questions below:

Additional Information

Please enter additional information. **All questions are required.**

Foot and Ankle Orthotics

| | | | | |
|---|-----------------------|----------------------------------|----------------------------------|-----------------------|
| Is this an orthotic for (select one): | <input type="radio"/> | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> |
| | Ankle | Foot | Knee | Wrist |
| Does member have a history of: | | | | |
| 1 Stroke or CVA affecting lower leg below the knee at ankle or foot? | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |
| 2 Cerebral Palsy affecting lower leg below the knee at ankle or foot? | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |
| 3 Neurologic Damage to leg below the knee at ankle or foot? | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |
| 4 Contracture to lower leg below the knee at ankle or foot? | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |

Review Request

Knee Orthotics

| | | | | |
|--|----------------------------------|-----------------------|----------------------------------|-----------------------|
| Is this an orthotic for (select one): | <input type="radio"/> | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> |
| | Ankle | Foot | Knee | Wrist |
| Does member have a history of: | | | | |
| 1 Stroke or CVA affecting lower leg at the knee | <input type="radio"/> | <input type="radio"/> | <input checked="" type="radio"/> | |
| | Yes | No | Unknown | |
| 2 Cerebral Palsy affecting lower leg at the knee | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |
| 3 Neurologic damage to leg at the knee | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |
| 4 Contracture to lower leg at the knee | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| | Yes | No | Unknown | |

Wrist Orthotics

| | | | | |
|--|--------------------------------------|----------------------------|--|--|
| Is this an orthotic for (select one): | <input type="radio"/> Ankle | <input type="radio"/> Foot | <input type="radio"/> Knee | <input checked="" type="radio"/> Wrist |
| Does member have a history of: | | | | |
| 1 Stroke or CVA affecting lower arm at or below the wrist? | <input type="radio"/> Yes | <input type="radio"/> No | <input checked="" type="radio"/> Unknown | |
| 2 Cerebral Palsy affecting the lower arm at or below the wrist? | <input checked="" type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | |
| 3 Neurologic damage affecting the lower arm at or below the wrist? | <input checked="" type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | |
| 4 Contracture affecting the lower arm at or below the wrist? | <input checked="" type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | |

Additional Information

Please enter additional information. **All questions are required.**

Diabetic Shoes

| | | |
|---|--------------------------------------|-------------------------------------|
| 1 Previous amputation of other foot, or part of either foot? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 2 History of previous foot ulceration of either foot? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 3 History of pre-ulcerative calluses of either foot? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 4 Peripheral neuropathy with evidence of callus formation on either foot? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 5 Foot deformity of either foot? | <input checked="" type="radio"/> Yes | <input type="radio"/> No |
| 6 Poor circulation in either foot? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |

Figure 14

2.4 Submission/Attaching Documents

Review the **Attestation Statement** and click **I Agree**. You must click agree to submit the request.

To the best of my knowledge, the information I am submitting in this transaction is true, accurate, complete and is in compliance with applicable Department of Community Health policies and procedures. I am submitting this information to the Georgia Department of Community Health, Division of Medical Assistance, for the purpose of obtaining a prior authorization number.

I understand that any material falsification, omission or misrepresentation of any information in this transaction will result in denial of payment and may subject the provider to criminal, civil or other administration penalties.

I understand that this CMO pre-certification request does not guarantee payment, approval of service or member benefit eligibility for the service.

To accept this information and proceed with your transaction, please click 'I agree'.

I Agree

Review the information entered on the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

When the request is successfully submitted, the system displays the Alliant tracking number. The Alliant tracking ID is a 12 digit number that starts with "7". The Alliant tracking number may be used to search for the case via the portal but is not the PA ID used for claims submission or adjudication. **The CMO authorization number is used for claims submission/adjudication.** The CMO authorization number is added to the PA on the portal once the CMO reviews the PA and sends the decision data to Alliant.

GMCF Tracking ID : 718020850002 Wellcare Health Plans Inc. Authorization ID : Not Available Status : Pending

At this point, supporting documentation may be attached to the PA. Go to **Create an Attachment** near the middle of the page. This section includes checkboxes for each required document. It is preferable to attach one file with all the documents. To attach the file, click **Browse**; find and open the file. The file name displays in the attachment panel. Click **Attach File**. The attached file displays in the **Attach File** table.

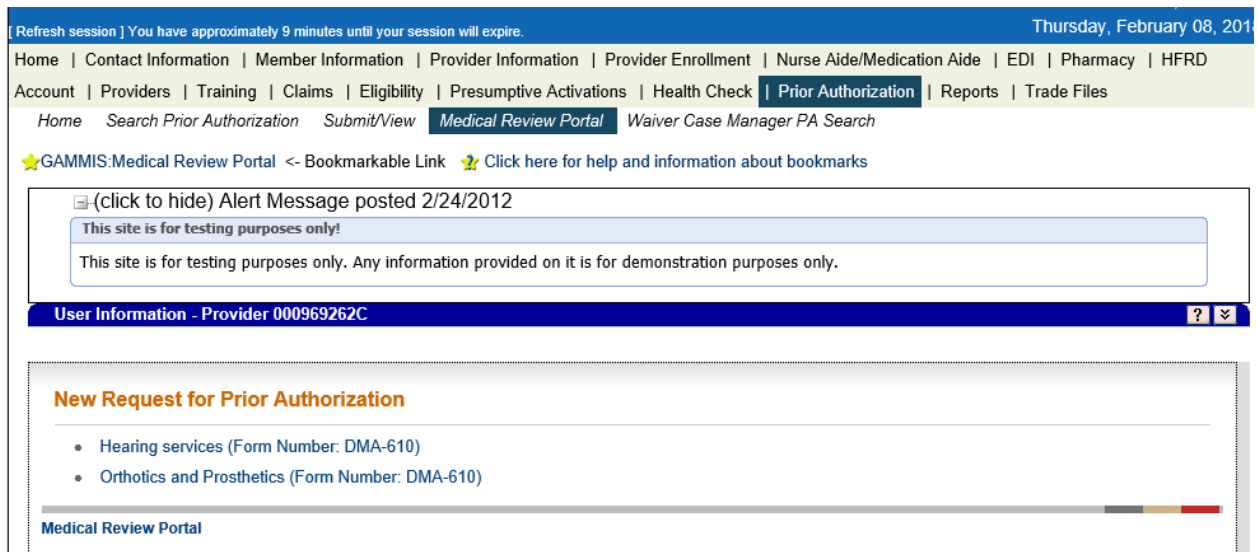
Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".

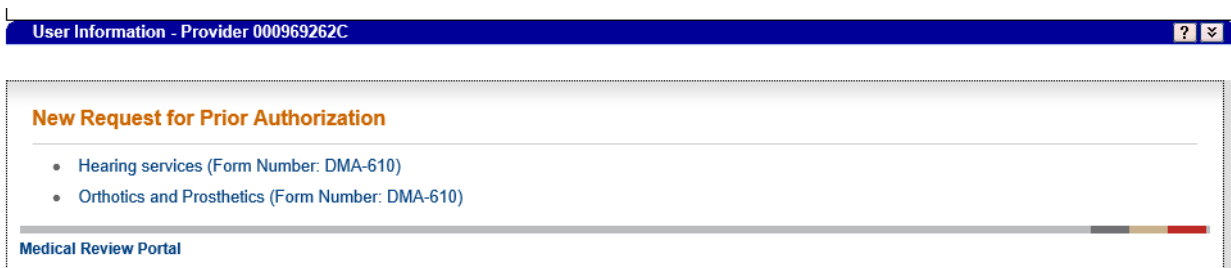
3.1 Initiate a Hearing PA Request

Follow these instructions to initiate a new CMO PA request.

1. Go to the GA Web Portal at www.mmis.georgia.gov.
2. Login with assigned user ID and password.
3. On the portal secure home page, click the **Prior Authorization** tab.
4. Then click **Medical Review Portal**; Then select **Enter a New Authorization Request**.



5. A list displays the request types applicable to the requesting provider's category of service.



6. Click the request type to be entered. (Hearing Services)

7. When the selected request type may be entered as a FFS PA or CMO PA, the user is prompted to select FFS or one of the Care Management Organizations.

New Request for Prior Authorization

Orthotics and Prosthetics (Form Number: DMA-610)

To find a Member or Provider click the next to the ID box

Select FFS or a CMO PA : Fee for Service
 Amerigroup Community Care
 CareSource Georgia Co.
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID:

Service Provider ID : 000969262C

Submit

Medical Review Portal

8. For CMO PA entry, click the button next to the specific CMO in which the member is enrolled and enter the member’s Medicaid ID number. **(Note the Service Provider ID is pre-populated).** Then select **Submit**.

New Request for Prior Authorization

Orthotics and Prosthetics (Form Number: DMA-610)

To find a Member or Provider click the next to the ID box

Select FFS or a CMO PA : Fee for Service
 Amerigroup Community Care
 CareSource Georgia Co.
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID: 1111111111

Service Provider ID : 000969262C


Submit

Medical Review Portal

9. If the member is not associated with the selected CMO, the **error** will be displayed.

New Request for Prior Authorization

Orthotics and Prosthetics (Form Number: DMA-610)

To find a Member or Provider click the  next to the ID box

Select FFS or a CMO PA : Fee for Service
 Amerigroup Community Care
 CareSource Georgia Co.
 Peach State Health Plan
 Wellcare Health Plans Inc.

Member Medicaid ID:  DESYNE J STANDFORD
 Service Provider ID : RAYMOND ALDRIDGE, MD, P.C.

ERROR: Member is not enrolled in selected CMO.
Warning: All Out Of Network Providers Are Required to Submit Authorization for all Services Rendered.

[Submit](#)

3.2 Enter Request Information

Member and Service Provider Information is already populated based on the information selected in the previous page. (Greyed out member Medicaid ID and provider Medicaid ID)

Orthotics & Prosthetics / Hearing Services

Please verify that the member name represents the correct member for this request. If not, please select under Prior Authorization the 'Submit/View' link to re-enter the correct information. If you need assistance please select under Contact Information the 'Contact Us' link, or call the Provider Contact Center at 1-800-766-4456.

Please provide the required information for this request. When you have completed entering data for this request, select the 'Review Request' link at the bottom of the page.

Prior authorization or pre-certification does not guarantee payment, approval of service or member benefit eligibility for the service.

Member Information

| Member ID | Last Name | First Name | MI | Suffix | DOB | Gender |
|--------------|---------------|------------|----|--------|------------|--------|
| 222111493580 | FRANCO-MELERO | ANGEL | | | 07/22/2007 | M |

Service Provider Information

| Provider ID | Name and Address | Phone | Taxonomy (Specialty) |
|-------------|---|--------------|---------------------------------------|
| 000969262C | RAYMOND ALDRIDGE, MD, P.C. 3 HOSPITAL PARK MOULTRIE, GA 31768 | 229-382-5114 | - Audiologist - Audiology Services |

The system also populates the requesting provider's contact information in the **Contact Information** section. The 'Contact Name', 'Contact Phone', and 'Contact Fax' are required. If this information is missing, enter the information in the boxes provided. All contact information may be edited if incorrect.

Contact Information

* Contact Name: * Contact Email:
 Contact Phone: Ext. * Contact Fax:

The **Request Information** section captures the option for providers to select the Place of Service. Users have the option to select “**Outpatient Hospital**”, “**Home**”, or “**Other**”.

Request Information

* Place of Service : Outpatient Hospital Office Other

The **Diagnosis Section** table captures the diagnosis code, code description, diagnosis date, primary diagnosis indicator, and diagnosis type (ICD9 or ICD10). If the date of service is 10/1/2015 or greater, an ICD-10 diagnosis code should be used. Only one primary diagnosis may be entered although more than one admission diagnosis may be entered. Users have the option to search the diagnosis code (by selecting the magnifying glass (🔍)) or enter the diagnosis code manually. The date calendar will populate for users to select the date on the calendar or you can enter the date manually. Once the data is entered select the “**Add Button**”. This will save the data entered.

* **Diagnosis**

| Diag Code | Diagnosis Description | Date | Primary | Type | |
|----------------------|---------------------------------------|----------------------|---------|--------|-------------|
| H90.3 | SENSORINEURAL HEARING LOSS, BILATERAL | 02/07/2018 | Yes | ICD-10 | EDIT DELETE |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | | | ADD |

The **Procedure Section** table captures CPT Code, CPT code description (auto-populated), procedure ‘From Date’ and ‘To Date’, units requested, requested priced/unit, and modifiers (if applicable). The Equipment Make, Model, Manufacturer ID, and Serial No fields are all text fields which users can manually add information in these fields if applicable but are not required unless specified by CMO policy. **Prior Authorization Procedure Code Lookup Tool** is a direct link for CMO providers to use to determine if a procedure code requires a PA.

Prior Authorization Procedure Lookup Tool

Procedures

| CPT Code | CPT Description | From Date | To Date | Months or Units of Service Requested | Requested Price/Unit | Mod 1 | Mod 2 | Equipment Make | Equipment Model | Manufacturer ID | Serial No | |
|----------------------|-----------------------------|----------------------|----------------------|--------------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------|
| V5247 | HEARING AID, PROG, MON, BTE | 02/01/2018 | 05/31/2018 | 1 | 1,949.00 | | | | | | | EDIT DELETE |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD CANCEL |

Note: Like the Diagnosis Code Section, select **Add** to add the procedure code to the request. When **Add** is selected, a blank procedure line displays, and the **Edit** button is available on the procedure line. If users need to **Edit** any previous information, select the **Edit** button and enter the corrected data, then select **Save** to store the updates.

Comments Section allows users to enter additional information that will be helpful for judgement of authorization approval. Select “**Yes**” or “**No**” if the member has retro eligibility in the table below the Comments Section.

Comments / Message

This member have retro eligibility for the submitted dates of service ? Yes No

Repairs and Replacements section should be completed if priced amount is over \$250.00. The Manufacturer ID, Serial No, Warranty Registration Number, Date of Original Purchase, and Manufacturer Warranty Duration (in months) are needed.

For Repairs / Replacements over \$200.00

| Manufacturer ID | Serial No | Warranty Registration Number | Date of Original Purchase | Manufacturer Warranty Duration (In Months) | |
|----------------------|----------------------|------------------------------|---------------------------|--|-------------|
| 29-4525656 | 125265636 | 02-7565356 | 01/01/2018 | 1 | EDIT DELETE |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | ADD |

Therapist/Other Service Provider Justification Information section captures the following required information: audiologist name, Georgia license/certification number, member’s height and weight. Therapist information and justification for services may be provided but is optional. Lastly, answer “**Yes**” or “**No**” if a signed physician’s prescription or Certificate of Medical Necessity is on file within 90 days of request. Then Select **Review Request** when all data is entered on this form.

| Therapist Information | | Patient Information | |
|---|--|---------------------------|---------------------------|
| * Audiologist Name : | * Georgia License / Certification Number : | Patient Height (inches) : | Patient Weight (pounds) : |
| welch givens | AUD123456 | 32 in. | 150 lb. |
| Justification and Circumstances for Requested Services : | | | |
| Describe why the patient needs O/P, medical justification for services requested. | | | |
| see attached notes | | | |
| Was a signed physician's prescription or Certificate of Medical Necessity on file within 90 days of request ? <input type="radio"/> Yes <input checked="" type="radio"/> No | | | |

3.3 Submission/Attaching Documents

Review the **Attestation Statement** and click **I Agree**. You must click agree to submit the request.

To the best of my knowledge, the information I am submitting in this transaction is true, accurate, complete and is in compliance with applicable Department of Community Health policies and procedures. I am submitting this information to the Georgia Department of Community Health, Division of Medical Assistance, for the purpose of obtaining a prior authorization number.

I understand that any material falsification, omission or misrepresentation of any information in this transaction will result in denial of payment and may subject the provider to criminal, civil or other administration penalties.

I understand that this CMO pre-certification request does not guarantee payment, approval of service or member benefit eligibility for the service.

To accept this information and proceed with your transaction, please click 'I agree'.

I Agree

Review the information entered on the request. To change information entered, click **Edit Request**. Otherwise, click **Submit Request**.

When the request is successfully submitted, the system displays the Alliant tracking number. The Alliant tracking ID is a 12 digit number that starts with "7". The Alliant tracking number may be used to search for the case via the portal but is not the PA ID used for claims submission or adjudication. **The CMO authorization number is used for claims submission/adjudication.** The CMO authorization number is added to the PA on the portal once the CMO reviews the PA and sends the decision data to Alliant.

GMCF Tracking ID : 718020850003 Amerigroup Community Care Authorization ID : Not Available Status : Pending

At this point, supporting documentation may be attached to the PA. Go to **Create an Attachment** near the middle of the page. This section includes checkboxes for each required document. It is preferable to attach one file with all the documents. To attach the file, click **Browse**; find and open the file. The file name displays in the attachment panel. Click **Attach File**. The attached file displays in the **Attach File** table.

Create an Attachment

If you want to attach a document to this Request, click on "Browse...", select a document and then, click on "Attach File".