**EPSDT Assistive technology – Service TYPE 0092**

**Required Service Authorization Information**

**Items intended to be used in a school setting that are needed for educational purposes are not covered.**

1. Provide Date On Evaluation Report or Physician’s/Practitioner’s LMN:
2. Signed by Physician/Nurse Practitioner/Physician Assistant/Therapist: Yes No
3. Provider Contact Name & Number:
4. Provide the diagnosis related to the Assistive Technology (AT) request:
5. Date of Injury/Illness/Surgery:
6. Level of Need:
	1. Acute Need: Yes/No
	2. Chronic or long-term need: Yes/No
7. Is this a Retro Review: Yes / No
8. \*Describe how the AT will treat the member’s medical condition.
9. \*Describe the individual’s functional limitation and its relationship to the requested AT item:
10. \*Describe any conjunctive treatment related to the use of the item:
11. \*How was the need previously met :
12. \*Identify changes that have occurred which necessitate the AT request:
13. \*Describe other alternatives tried or explored and describe the success or failure of these alternatives:
14. \*Has the AT item been trialed successfully: Yes/No. If yes, describe benefit and use:
15. \*List specialized equipment the patient requires:
16. \*Describe the quantity needed and the medical reason the requested amount is needed:
17. \*Describe the frequency of use and the estimated length of use of the item:
18. \*List Therapeutic Interventions (Medications, Nutrition, Coping Skills Etc.):
19. \*List Mobility Impairments and its relationship to the requested AT item:
20. \*List Endurance impairments and its relationship to the requested AT item:
21. \*List Activity restrictions and its relationship to the requested AT item:
22. \*List Respiration Impairments and its relationship to the requested AT item:
23. \*List Speech Impairments and its relationship to the requested AT item:
24. \*Does patient have Any Skin Breakdown: Yes / No
25. \*Is Assistance Required With ADL’s: Yes / No
26. \*Are Nutritional Supplements Required: Yes / No
27. \*Is the Item Suitable For Use In The Home: Yes / No.

If yes, explain in Atrezzo Connect Clinical Information note box (include how the AT item is required in the member’s home or community environment)

1. \*Will the Assistive Technology requested be used during school hours? If yes, explain in Atrezzo Connect Clinical Information note box.
	1. Is AT included in the member’s IEP (Individualized Education Plan)?
	2. Please provide documentation obtained from the school indicating reason AT is not included in member’s IEP.
2. Does the Caregiver Demonstrate A Willingness / Ability to Use the Equipment: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
3. Is Equipment for:
	1. Rental: Yes/No
	2. Purchase: Yes/No

If yes, was a 60-day rental required and/or achieved prior to purchase?

1. Add in notes: The Actual Cost per Unit and/or Usual and Customary as applicable
2. Add in Notes: Total Dollars requested

\*Clinical Information: Atrezzo Connect Clinical Information note box is for entering specific information as noted in numbers 8 through 28(?) on this document

**Out of State Providers: Please select one of the four questions which best meets the reason you are requesting Out of State Provider Services and specify how the request meets the selected reason:**

**Services provided out of state for circumstances other than these specified reasons shall not be covered.**

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

Explain selected response:

Enrolled in Virginia Medicaid: Yes No

**Out of State Providers Not Enrolled in Virginia Medicaid may enroll with Virginia Medicaid by going to:**

**(KePRO: add link to Provider Enrollment).** At the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box.

**It may take up to 10 business days to become a Virginia participating provider.**