Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers**

DATE: **July 1, 2007**

SUBJECT: **Section V Provider Manual Update Transmittal**

Provider Manual	Transmittal Number
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Explanation of Updates

Attached is a copy of form DMS-873, a 3-page multi-purpose form that includes its own instructions. Effective for dates of service on and after July 1, 2007, Residential Care Facilities (RCFs) that are enrolled as Personal Care providers must use this form to record personal care aides' daily notes concerning their clients and to log service delivery. The form is available in Portable Document Format (.pdf) for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Paper versions of this update transmittal have updated pages attached to file 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 need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

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

Arkansas Medicaid provider manuals (including update transmittals), official notices 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.

Roy Jeffus, Director

Claim Forms

Red-ink Claim Forms

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

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450	Business Form Supplier
EPSDT – DMS-694**	EDS - 1-800-457-4454
Visual Care – DMS-26-V	EDS - 1-800-457-4454
Inpatient Crossover – EDS-MC-001	EDS - 1-800-457-4454
Long Term Care Crossover – EDS-MC-002	EDS - 1-800-457-4454
Outpatient Crossover – EDS-MC-003	EDS - 1-800-457-4454
Professional Crossover – EDS-MC-004	EDS - 1-800-457-4454

** A printable **PROVIDER INTEROFFICE DOCUMENTATION ONLY** version of this form is available below under Arkansas Medicaid Forms.

Claim Forms

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

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J400	Business Form Supplier
Hospice/INH Claim Form – DHS-754	EDS – 1-800-457-4454

Arkansas Medicaid Forms

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

In order by form name:

Form Name	Form Number
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form - Medicaid XIX	EDS-AR-004
AFMC Personal Care Assessment and Service Plan for Medicaid Beneficiaries Under Age 21	AFMC-201

Form Name	Form Number
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	AFMC-103
AFMC Request For Bilaminate Skin Substitutes	AFMC-RBSS
Amplification/Assistive Technology Recommendation Form	DMS-686
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Assisted Living Waiver Plan of Care	AAS-9565
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
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	AFMC-102
CHMS Request for Prior Authorization	AFMC-101
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
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
Disproportionate Share Questionnaire	DMS-628
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 Claim Form — You may print this version for use in charts and electronic billing documentation; however, if you submit a paper claim for billing, you must use the red-ink version (see Red-ink Claim Forms above.)	EPSDT-DMS-694
EPSDT Provider Agreement	DMS-831
Evaluation Form Lower-Limb	DMS-646
Explanation of Check Refund	EDS-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

Form Name	Form Number
Individual Renewal Form for DDTCS Therapists & School Based Therapists	DMS-0663
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	None
Medicaid Claim Inquiry Form	EDS-CI-003
Medicaid Form Request	EDS-MFR-001
Medical Assistance Dental Disposition	DMS-2635
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
Personal Care Assessment and Service Plan	DMS-618
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Prescription Drug Prior Authorization and Extension of Benefits Request Form	DMS-2694
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
Prosthetic-Orthotic Lower-Limb Amputee Evaluation	DMS-650
Prosthetic-Orthotic Upper-Limb Amputee Evaluation	DMS-648
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Enrollment Application and Contract Package	AppMaterial
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
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 Orthodontic Treatment	DMS-32-0

Form Name	Form Number
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
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
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	None
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9565
Address Change
AFMC-101
AFMC-102
AFMC-103
AFMC-201
AFMC-RBSS
Authorization for Automatic Deposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0663
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2694
DMS-2698
DMS-32-A
DMS-32-O
DMS-601
DMS-602
DMS-612
DMS-615
DMS-616
DMS-618
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-646
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-653
DMS-671
DMS-673
DMS-679
DMS-683
DMS-686
DMS-693
DMS-694 chart version
DMS-694 sample
DMS-699
DMS-831
ECSE-R
EDS-AR-004
EDS-CI-003
EDS-CR-002
EDS-MFR-001
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
- APS Healthcare Midwest (APS)
- Arkansas Department of Education, Health and Nursing Services Specialist
- Arkansas Department of Education, Special Education
- Arkansas DHHS Division of Human Services - Aging and Adult Services
- Arkansas DHHS Division of Human Services – Appeals and Hearings Section
- Arkansas DHHS Division of Human Services, Child Care and Early Childhood Education, Child Care Licensing Unit
- Arkansas DHHS Division of Human Services, Children and Family Services, Contracts Management Unit
- Arkansas DHHS Division of Human Services, Children's Services
- Arkansas DHHS Division of Human Services, County Operations - Customer Assistance Section
- Arkansas DHHS Division of Human Services, Medical Services
- Arkansas DHHS Division of Human Services, Medical Services Dental Care Unit
- Arkansas DHHS Division of Human Services, Medical Services Director
- Arkansas DHHS Division of Human Services, Medical Services Financial Activities Unit
- Arkansas DHHS Division of Human Services, Medical Services Hearing Aid Consultant
- Arkansas DHHS Division of Human Services, Medical Services Medical Assistance Unit
- Arkansas DHHS Division of Human Services, Medical Services Pharmacy Unit-Utilization Review Section
- Arkansas DHHS Division of Human Services, Medical Services Third-Party Liability Unit
- Arkansas DHHS Division of Human Services, Medical Services UR Benefit Extension Requests Section
- Arkansas DHHS Division of Human Services, Medical Services UR/Home Health Extensions
- Arkansas DHHS Division of Human Services, Medical Services Utilization Review Section
- Arkansas DHHS Division of Human Services, Medical Services Visual Care Coordinator
- Arkansas DHHS Division of Human Services, Medical Services, Provider Reimbursement Unit
- Arkansas DHHS, Division of Health
- Arkansas DHHS, Division of Health, Health Facility Services
- Arkansas DHHS, Division of Human Services, Accounts Receivable

Arkansas Foundation For Medical Care
Arkansas Hospital Association Contact Information
Arkansas Medicaid Provider Enrollment Unit
ARKids First-B ID Card Example
ARKids First-B Telephone Number
Central Child Health Services Office
ConnectCare Helpline
County Codes
CPT Ordering Information
EDS Claims Department
EDS EDI Support Center (formerly AEVCS Help Desk)
EDS Inquiry Unit
EDS Manual Order Address
EDS Pharmacy Help Desk
EDS Provider Assistance Center (PAC)
EDS 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 Health
Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment
Health Care Declarations
ICD-9-CM Ordering Information
Immunizations Registry Help Desk – DHHS Division of Health
Medicaid ID Card Example
Medicaid Reimbursement Unit Communications Hotline
Medicaid Tooth Numbering System
National Supplier Clearinghouse
Primary Care Physician (PCP) Enrollment Voice Response System
Provider Qualifications Division of Mental Health Services
Select Optical
Standard Register
Table of Desirable Weights
U.S. Government Printing Office
Vendor Performance Report

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A								A
B							57 OTHER PRV ID	B
C								C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX										68

69 ADMIT DX		70 PATIENT REASON DX			71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04L NUBC National Uniform Billing Committee TFP24394485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code

57. Phone Number ( ) –

58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Request for Extension of Benefits

Provider
Address
Address

City _____ State _____ Zip Code _____

Patient's Name _____

Address _____

City _____ State _____ Zip Code _____

Medicaid ID Number _____ Birthdate _____ Sex _____

Diagnoses _____

Benefit Extensions Requested

Procedure Code	Type of Service Code or Modifiers After 07/01/07	Service From Date	Service To Date	Units

Attach a summary and medical records as needed to justify medical necessity.

Provider ID Number/Taxonomy Code _____

Provider's Signature _____ Date _____

Request Disposition

(To be completed by reviewer)

Approved _____ Denied _____ Control Number _____

Procedure Code	Type of Service Code	Service From Date	Service To Date	Units

Instructions for Completion of Request for Extension of Benefits – DMS-699 (Rev.4/07)

ALL REQUIRED FIELDS OF FORM DMS-699 MUST BE CORRECTLY COMPLETED BY ENTERING THE FOLLOWING INFORMATION

Enter Provider Name, Address, City, State, Zip Code – **REQUIRED**

Enter Patient's Full Name – **REQUIRED**

Enter Patient's Address, City, State, Zip Code – If Available

Enter Patient's Arkansas Medicaid ID Number, Birth Date, and Sex – **REQUIRED**

Enter Diagnoses -Primary to Request First- Then Additional if Applicable – **REQUIRED**

Enter Correct Medicaid Procedure Code for Items Requested for Extension – **REQUIRED**

Enter Correct "Type of Service Code" or **All Applicable Modifiers (After 07/01/07)** – **REQUIRED**

Enter From Date of Service – **REQUIRED**

Enter To Date of Service – **REQUIRED**

Enter Correct Number of Units Being Requested – **REQUIRED**

Enter Provider ID Number – **REQUIRED**

Enter Provider Taxonomy Code - if Applicable

Complete with an Original Signature by Provider or Provider's Authorized Representative -**REQUIRED**

ATTACH A SUMMARY AND MEDICAL RECORDS AS NEEDED TO JUSTIFY MEDICAL NECESSITY – **REQUIRED**

COUNTY OFFICE

EPSDT

Provider Inter-office Use
Patient Charting and Electronic Billing Documention Version Only
This Copy Not To Be Used For Paper Claim Billing

Section I - Patient Identification

PATIENT'S LAST NAME (1)	FIRST (2)	MI (3)	SEX (4) ☐ M ☐ F	PATIENT'S MEDICAID ID NO. (5)

CASEHEAD'S NAME (6)	COUNTY OF RESIDENCE (7)	DATE OF BIRTH (8) MO DAY YEAR	STREET ADDRESS (9)	CITY (10)

IF PATIENT IS A REFERRAL (11) ENTER NAME OF REFERRING PHYSICIAN / PROVIDER ID NUMBER/TAXONOMY CODE	MEDICAL RECORD NUMBER (12)	PROVIDER PHONE NUMBER PAY TO: PROVIDER NAME AND ADDRESS (13)
OTHER HEALTH INSURANCE COVERAGE (14) (ENTER NAME OF PLAN AND POLICY NUMBER.)	WAS CONDITION RELATED TO: (15) A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN ACCIDENT ☐ YES ☐ NO	PAY TO PROVIDER ID NUMBER/TAXONOMY CODE

PRIMARY DIAGNOSIS OR NATURE OF INJURY (16)	DIAGNOSIS CODE	TYPE OF SCREEN (18) PERIODIC _____ INTER-PERIODIC _____

Section II - Examination Report (20)

Type of Test or Examination		NORMAL	ABNORMAL	COUNSELED	TREATED	REFERRED
A. Basic Screening—						
1. Growth and Nutrition	(A)					
2. Development Assessment	(B)					
3. Unclothed Physical	(C)					
a. Neurological Exam	(D)					
b. Cardiac Status	(E)					
4. Vision	(F)					
5. Hearing	(G)					
6. Teeth (Children under 3 years)	(H)					
7. Lab Tests (Appropriate for age and population group)	(I)					
a. Hematologic	(J)					
b. Urinalysis	(K)					
c. Lead Level Screen	(L)					
d. Other (Specify)	(M)					
B. Immunization Status	(N)					
C. Other (Specify)	(Z)					

COMMENTS (21)

(22) A DATE OF SERVICE FROM TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G. PERFORMING PROVIDER ID NUMBER/ TAXONOMY CODE

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements of documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws. No additional charges for compensable services will be made against anyone; payment will be accepted as payment in **FULL,** that the above services claimed for payment have been completed and that the above services have been furnished in full compliance (without discrimination) within the provisions of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

(26) PROVIDER'S SIGNATURE _____ BILLING DATE (27)

(23) **TOTAL CHARGES**	
(24) **COVERED BY INSURANCE**	
(25) **BALANCE DUE**	

FOR OFFICE USE (28)

DMS-694 (Rev. 7/07)

Instructions for Completion of the EPSDT Claim Form – DMS-694

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those which require attachments or manual pricing.

To bill for a Child Health Services (EPSDT) screening service, use the claim form DMS-694. The numbered items correspond to numbered fields on the claim form. The DMS-694 is used as a combined referral, screening results document and a billing form. Each screening should be billed separately, providing the appropriate information for each of the screening components. The following numbered items correspond to numbered fields on the claim form.

Medical services such as immunizations and laboratory procedures may also be billed on the DMS-694 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print the EDS Claims Department contact information.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

Field Name and Number	Instructions for Completion
1. Patient's Last Name	Enter the patient's last name.
2. Patient's First Name	Enter patient's first name.
3. Patient's Middle Initial	Enter patient's middle initial.
4. Patient's Sex	Check "M" for male or "F" for female.
5. Patient's Medicaid ID No.	Enter the entire 10-digit patient Medicaid identification number.
6. Casehead's Name	Enter the casehead name for TEA children only. Patient's name has been requested in Blocks 1, 2 and 3.
7. County of Residence	Enter the patient's county of residence.
8. Date of Birth	Enter the patient's date of birth in month and year format as it appears on the Medicaid identification card.
9. Street Address	Enter the patient's street address.
10. City	Enter the patient's city of residence.
11. If a Patient is a Referral Enter Name of Referring Physician Provider Identification Number/Taxonomy Code	If the patient is a referral, enter the name of the referring physician and his or her provider identification number and taxonomy code.
12. Medical Record Number	This is an optional entry that the provider may use for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alpha characters will be accepted. This number will appear on the Remittance Advice (RA) and is a method of identifying payment of the claim.

Field Name and Number	Instructions for Completion
13. Provider Phone Number Pay To: Provider Name and Address Pay To: Provider Number	Enter the provider's complete name, address, provider identification number, and taxonomy code. If a clinic billing is involved, use the clinic provider identification number. Telephone number is requested but not required.
14. Other Health Insurance Coverage (Enter Name of Plan and Policy Number)	If applicable, enter the name of the insurance plan and the policy number of any health insurance coverage carried by the patient other than Medicaid. The patient's Medicaid identification card should indicate "Yes" if other coverage is carried by the beneficiary.
15. Was Condition Related to:	
A. Patient's Employment	Check "Yes" if the patient's condition was employment related. If the condition was not employment related, check "No."
B. An Accident	Check "Yes" if the patient's condition was related to an accident. Check "No" if the condition was not accident related.
16. Primary Diagnosis or Nature of Injury	Enter the description of the primary reason for treatment of the patient.
Diagnosis Code	Enter the ICD-9-CM Code that identifies the primary diagnosis.
18. Type of Screen Periodic Interperiodic	Not required for Medicaid. Completed by Human Services, if applicable.
SECTION II	
20. Examination Report	To be completed by screening provider at time of screen.
A. Basic Screening	
Item A, Numbers 1 through 6	Check "Normal" or "Abnormal" for each component. Check "Counseled," "Treated" or "Referred" as applicable.
Item A, Number 7	Give results of the lab tests performed at the time of screen.
Item B	Immunization status appropriate for age and health history. If immunization cannot be performed, note the reason along with the return appointment in "Comments" section.
Item C	Enter any other services rendered.
21. Comments	Briefly explain any problems identified and describe treatment or referral. If referred, indicate the name of the provider to whom the referral was made.
22. A. Date of Service	Enter the "from" and "to" dates of service for each service provided in MM/DD/YY format. A single date of service need not be entered twice on the same line.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.

Field Name and Number	Instructions for Completion
C. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given *(Explain Unusual Services or Circumstances)* Procedure Code (Identify)	Enter the appropriate HCPCS, CPT and state assigned procedure code and describe any services or circumstances, e.g., what age periodicity screen has been provided and describe procedures performed (including screen, lab test, immunizations, etc.).
D. Diagnosis Code	Enter the ICD-9-CM code, which corresponds with the procedures performed.
E. Charges	Enter the charges for the rendered services. These charges should be the provider's current usual and customary fee to private clients.
F. Days or Units	Enter days or units of service rendered.
G. Performing Provider Number	If the billing provider noted in Block 13 is a clinic or group, enter the attending provider's provider identification number and taxonomy code.
23. Total Charges	Enter the total of Column 22E. This block should contain a sum of charges for all services indicated on the claim form.
24. Covered by Insurance	Enter the total amount of funds received from other sources. The source of payment should be indicated in Block 14. If payment was received from the patient, indicate in Block 14, but DO NOT include the amount in Block 24.
25. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.
26. Provider's Signature	The provider or designated authorized individual must sign the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
27. Billing Date	Enter date signed.

Instructions for Completion of Request for Extension of Benefits – DMS-699 (Rev.4/07)

ALL REQUIRED FIELDS OF FORM DMS-699 MUST BE CORRECTLY COMPLETED BY ENTERING THE FOLLOWING INFORMATION

Enter Provider Name, Address, City, State, Zip Code – **REQUIRED**

Enter Patient's Full Name – **REQUIRED**

Enter Patient's Address, City, State, Zip Code – If Available

Enter Patient's Arkansas Medicaid ID Number, Birth Date, and Sex – **REQUIRED**

Enter Diagnoses -Primary to Request First- Then Additional if Applicable – **REQUIRED**

Enter Correct Medicaid Procedure Code for Items Requested for Extension – **REQUIRED**

Enter Correct "Type of Service Code" or **All Applicable Modifiers (After 07/01/07)** – **REQUIRED**

Enter From Date of Service – **REQUIRED**

Enter To Date of Service – **REQUIRED**

Enter Correct Number of Units Being Requested – **REQUIRED**

Enter Provider ID Number – **REQUIRED**

Enter Provider Taxonomy Code - if Applicable

Complete with an Original Signature by Provider or Provider's Authorized Representative -**REQUIRED**

ATTACH A SUMMARY AND MEDICAL RECORDS AS NEEDED TO JUSTIFY MEDICAL NECESSITY – **REQUIRED**

Field Name and Number	Instructions for Completion
C. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given *(Explain Unusual Services or Circumstances)* Procedure Code (Identify)	Enter the appropriate HCPCS, CPT and state assigned procedure code and describe any services or circumstances, e.g., what age periodicity screen has been provided and describe procedures performed (including screen, lab test, immunizations, etc.).
D. Diagnosis Code	Enter the ICD-9-CM code, which corresponds with the procedures performed.
E. Charges	Enter the charges for the rendered services. These charges should be the provider's current usual and customary fee to private clients.
F. Days or Units	Enter days or units of service rendered.
G. Performing Provider Number	If the billing provider noted in Block 13 is a clinic or group, enter the attending provider's provider identification number and taxonomy code.
23. Total Charges	Enter the total of Column 22E. This block should contain a sum of charges for all services indicated on the claim form.
24. Covered by Insurance	Enter the total amount of funds received from other sources. The source of payment should be indicated in Block 14. If payment was received from the patient, indicate in Block 14, but DO NOT include the amount in Block 24.
25. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.
26. Provider's Signature	The provider or designated authorized individual must sign the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
27. Billing Date	Enter date signed.

Arkansas Foundation for Medical Care, Inc.

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER					
☐ **INITIAL** ☐ **RECERT** ☐ **MODIFICATION** ☐ **EXT OF BENEFITS**			**START DATE:**		
PROVIDER NAME:			**PROVIDER MAILING ADDRESS:**		
PROVIDER IDENTIFICATION #/TAXONOMY CODE:			**PROVIDER PHONE & CONTACT PERSON:**		
BENEFICIARY NAME: (LAST, FIRST, MI)			**BENEFICIARY MEDICAID ID #:**		
BENEFICIARY MAILING ADDRESS:			**DATE of BIRTH:**	**SEX:** ☐ **MALE** ☐ **FEMALE**	
PRESCRIBING PHYSICIAN:			**PROVIDER IDENTIFICATION #/TAXONOMY CODE:**		
PROCEDURE CODE	**MOD 1**	**MOD 2**	**MOD 3**	**DESCRIPTION OF ITEMS REQUESTED**	**UNITS REQUESTED**

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

PROVIDER SIGNATURE **DATE**

SECTION B - TO BE COMPLETED BY THE PHYSICIAN			
EST. LENGTH OF NEED: _____**WKS** _____ **MONTHS** _____**PERM**	**EPSDT REFERRAL:** ☐ **YES** ☐ **NO** ☐ **N/A**	**CURRENT HEIGHT:** **INCHES**	**CURRENT WEIGHT:** **LBS**
DIAGNOSIS & ICD-9 CODE:	**DIAGNOSIS & ICD-9 CODE:**	**DIAGNOSIS & ICD-9 CODE:**	

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

MEDICAL NECESSITY FOR REQUESTED SERVICES:

PHYSICIAN SIGNATURE **DATE**

****A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required. Please retain a copy of this form in your files.**

Send completed form to:

Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters

PO Box 180001

Fort Smith, AR 72918

AFMC-103(7/07)

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.
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PHYSICIAN INFORMATION:	Enter the prescribing physician's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier(s) 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 being 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-9 CODES:	In the first space, list the diagnosis & ICD9 code that represents the primary reason for ordering this item. List any additional diagnosis & ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
MEDICAL NECESSITY:	The physician must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are not acceptable.
**PRESCRIPTION:	A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
**LETTER OF MEDICAL NECESSITY:	If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required.

REQUEST FOR EXTENSION OF BENEFITS FOR CLINICAL, OUTPATIENT, LABORATORY AND X-RAY SERVICES

Arkansas Foundation for Medical Care, Inc.
Attn: EOB Review
P O Box 180001
Fort Smith, AR 72918-0001

DATE: ____/____/____

Important: If all required information is not completed, the form will be returned to provider.

(1) **PERFORMING PROVIDER**	(2) **PROVIDER ID#/TAXONOMY CODE**
(3) **MAILING ADDRESS**	(4) **GROUP PROVIDER ID #** __ __ __ __ __ __ __ __ __ __
CITY **STATE** **ZIP CODE**	
(5) **PERFORMING PROVIDER SIGNATURE & CREDENTIALS**	

(6) **BENEFICIARY NAME [LAST]** **[FIRST]** **[M.I.]**		
(7) **ADDRESS**	**CITY** **STATE**	**ZIP CODE**
(8) **MEDICAID BENEFICIARY ID** (10 digits) __ __ __ __ __ __ __ __ __ __	(9) **DOB MM/DD/YY** ____/____/_____	**SEX** _____

To file a Request for Extension of Benefits, the following information is required:

(10) SERVICE FROM DATE	(11) SERVICE TO DATE	(12) TYPE OF SERVICE	(13) DIAGNOSIS CODE	(14) DIAGNOSIS CODE DESCRIPTION	(15) PROCEDURE CODE	(16) PROCEDURE CODE DESCRIPTION	(17) UNITS	**Request Disposition** *Completed By AFMC* DECISION APPROVED	DECISION DENIED	DATE OF REVIEW

Benefit Extension Control # _____
Completed by AFMC

When filing claim use the control number above to indicate the benefit extension is authorized.

Note: Attach copies of Medical Records/Supporting Documentation substantiating **medical necessity** of requested services/procedures.
[Instructions for requesting extension of benefits and completion of this form are included on the reverse side of this form.]
Comments:

Requirements for Requests for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services

Procedural Policy

To reduce delays in processing requests and to avoid returning requests due to incomplete and/or lack of documentation, the following procedures must be followed.

I. Requests for extension of benefits will be considered after a claim has been denied for exceeding the benefit limit.

II. The Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services (Form DMS-671) must be filed within 90 calendar days of the date of denial. Any request filed beyond the 90 calendar day deadline will be denied.

III. Extension of benefits will be denied if the original claim was denied for untimely filing (12 months beyond the date of service).

IV. AFMC EOB Review will consider extending benefits if ***all*** of the following documentation is received with request.

A. All fields of form DMS-671 must be correctly completed by entering the following information:

(1) Enter performing provider's name.
(2) Enter the provider ID # and taxonomy code of performing provider.
(3) Enter the address provider will use to receive correspondence regarding this extension.
(4) If the provider is a member of a group, enter the group provider ID #.
(5) Performing provider's signature and credentials must be entered in this field.
(6) Enter the beneficiary's full name.
(7) Enter the beneficiary's complete address.
(8) Enter the beneficiary's Medicaid ID #.
(9) Enter the beneficiary's date of birth and sex.
(10) Enter the service from date – claims for reimbursement must be filed in chronological order.
(11) Enter the service to date – dates of service must be listed in chronological order.
(12) Enter the type of service code (if claim was filed on paper prior to 07-01-07). Type of Service codes are indicated in the field directly preceding the billed procedure code on each Medical Assistance Remittance and Status Report.
(13) Enter the diagnosis code.
(14) Enter the diagnosis code description.
(15) Enter the procedure code and applicable modifier(s). (If there are more than 4 procedures, additional procedures must be added to a separate completed form.)
(16) Enter the procedure code description.
(17) Enter the number of units.

B. Copy of the Medical Assistance Remittance and Status Report stating benefits are exhausted for date of service. Do not send the claim form.

C. Clinical records must:

1. Be legible and include records supporting the specific request
2. Be signed by the performing provider
3. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
4. Include related diabetic and blood pressure flow sheets
5. Include current medication list for date of service
6. Include obstetrical record related to current pregnancy

D. Laboratory and radiology reports must include:

1. Clinical indication for lab and x-ray ordered
2. Signed orders for laboratory and radiology
3. Results signed by performing provider
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests

E. The Arkansas Medicaid Program automatically extends benefits when one of the following diagnoses exists and is entered as the primary diagnosis in both header and detail fields:

1. Malignant neoplasm (code range 140.0 – 208.91)
2. HIV, including AIDS (code 042)
3. Renal failure (code range 584 – 586)

F. Requests for reconsideration must be received within 30 calendar days of AFMC denial. Only one reconsideration will be allowed.

G. AFMC reserves the right to request further clinical documentation as deemed necessary to complete medical review.