

471-000-211 Form MC-10, "Prior Authorization Document Adjustment" and Completion Instructions

USE: Form MC-10, "Prior Authorization Document Adjustment," is used to adjust (correct, deactivate, or reactivate) an existing prior authorization document. Form MC-10 is most commonly used to adjust the following prior authorization documents:

- Form MC-9NF, "Prior Authorization Document for Nursing Facility Services," used for nursing facility and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) services; and
- Form MC-9, "Prior Authorization Document" used for Institutions for Mental Disease (IMD) services.

COMPLETION: Providers complete Form MC-10 *only* for IMD services. HHS Local Office or Medicaid Division staff complete Form MC-10 for nursing facility and ICF/MR services. Refer to 471 NAC 12-006.03 for instructions for common uses of Form MC-10 for nursing facility services.

1. Document Number: Copy the nine-digit number from the original prior authorization document.
2. Authorization Type: Check '3' if adjusting Form MC-9NF for nursing facility or ICF/MR services. Check '2' if adjusting Form MC-9 for IMD services.
3. Client Information: Enter the client's 11-digit Medicaid number and full name.
4. Provider Information: Enter the provider's 11-digit Medicaid provider number, name and address. **Note:** Form MC-10 is not used to change the Medicaid provider. If the provider changes, Form MC-10 is issued to inactivate the original prior authorization and a new prior authorization document is issued.
13. Effective Date: To deactivate an authorization, enter the appropriate date as the "TO" date.
14. Additional Information: Briefly explain the requested adjustment. This field may be used to correct an error on the original authorization or to delete the original authorization because it should not have been issued.
16. Signature Block: Providers do not sign or date Form MC-10. If Form MC-10 is completed by HHS Local Office or Medicaid Division staff, enter the name of the Local HHS Office, sign, and date Form MC-10 as the authorizing agent of the Department.
17. Effective Date of Payment to Nursing Facility: To reactivate an authorization, enter the date payment is to resume. If the client is readmitted to a nursing facility from which s/he was previously discharged, do not complete Form MC-10. A new Form MC-9NF must be completed.

DISTRIBUTION: Send the completed Form MC-10 to HHS F&S, Medicaid Division, P.O. Box 95026, Lincoln, NE 68509-5026. Form MC-10 is retained in the Local Office client's case file and Medicaid Division files. The provider copy is retained by the provider.



Prior Authorization Document Adjustment

FORM MC-10

1. Document Number

2. 1. Drug 2. Hospital 3. Nursing Facility
 4. Home Health Agency/Personal Care Aide Services/Hospital Outpatient
 5. Practitioner 6. Dental 7. Health Supplies
 8. Medically Handicapped Children

3. 11 Digit Client Medicaid I.D. Number _____ Client Name _____

4. Medicaid Provider Number

Name _____

Street _____

City _____ State _____ Zip Code _____

**THIS AUTHORIZATION IS VOID IF
CLIENT IS INELIGIBLE**

Enter **ONLY** the information required for this authorization. Submit the white and goldenrod copies to the **CENTRAL OFFICE** immediately.

5. Rate/Total Amount \$ _____

6.	CODE	NO.	RATE	DESCRIPTION OF SERVICE	AMOUNT
1					
2					
3					
4					
5					

7. Practitioner Name _____ 8. Practitioner License Number _____

9. ICD - 9CM DIAGNOSIS CODES

Primary

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Secondary

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Primary Surgical Procedure Code

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10. MR DIAGNOSIS CODE

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11. Medical Review Team Approval Care Level

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Signature _____ Date _____

12. Admission Date to Nursing Facility

Mo.	Day	Year

13. Effective Date

FROM

Mo.	Day	Year

 TO

Mo.	Day	Year

14. Additional Information

15. Diagnosis Description

16. I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Dept. of Health and Human Services. The Dept. of Health and Human Services is not responsible for lost, stolen or damaged rental items.

Local/State Office _____ **Sign Here** Signature of Authorizing Agent _____ Date _____

17. Effective Date of Payment to Nursing Facility

Mo.	Day	Year