NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicid and Long-Term Care

Request for Prior Authorization

1. Client Name (Last, First, Initial)	2. Client Medicaid Number

NOTE: This authorization is void if the client is ineligible for the Nebraska Medicaid or is enrolled in the Medicaid Managed Care Program at the time the service is provided. It is the responsibility of the provider to verify client Medicaid eligibility.

3. Provider Name	4. Provider NPI	
5. Provider Address	6. Provider Taxonomy	
7. Provider City, State, Zip Code + 4	8. Provider Phone Number	9. Provider Fax Number

SERVICES TO BE AUTHORIZED

10.	Procedure Code	Modifier	Units of Service	Unit Price	Description of Service	Do Not Complete **Amount Authorized**
a.						
b.						
c.						
d.						
e.						

11. Name of Prescribing Practitioner	12. Prescribing Practitioners NPI

13. Is Client in a Nursing Facility / ICF - DD
☐ Yes ☐ No

14. Rental Items Only

Item	Purchase Price	Date Delivered	New	Used
a.				
b.				
c.				
d.				
e.				

15. Diagnosis Code

17. Date Requested
From To

17. Requesting Provider Signature	18. Date of Request

19. Comments: (Medicaid Use Only)

20. Signature of Authorizing Agent	Date	Approve/Deny

Form MS-77 Instructions for Completion

USE: Form MS-77 is used to prior authorize payment for items as required by the Nebraska Medicaid Program (471-NAC-000). Copy this form for office use. Incomplete forms will be returned. DMEPOS prior authorizations are reviewed by the Department's Utilization Management Provider. Please contact the Department for this information.

Injectable medication prior authorizations are reviewed by the Department.

Completion: Providers shall complete Form MS-77 as follows:

1. **Client Name**: Enter the client's full name as listed on the Nebraska Medicaid Eligibility card
2. **Client Medicaid Number**: Enter the client's 11-digit Medicaid identification number as listed on the Nebraska Medicaid eligibility card
3. **Provider's Name:** Enter the name of the provider
4. **Provider's NPI:** Enter the provider's 10-digit National Provider Identifier (NPI)
5. **Provider's Taxonomy:** Enter the provider's 10-digit taxonomy code
6. **Provider's Address:** Enter the provider's complete street address
7. **Provider's City, State and Zip + 4:** Enter the provider's city, state and zip code + 4 numbers that are assigned to the billing address for the provider
8. **Provider's Phone Number:** Enter the phone number at which the person requesting the prior authorization may be contacted
9. **Provider's Fax Number:** Enter the provider's fax number
10. **Services to be Authorized:** A maximum of five services can be requested on each prior authorization request. For each service requested, enter the information listed below
    Procedure Code: Enter the procedure code
    Modifier: Enter the procedure code modifier, if applicable
    Units of Service: Enter the number of units requested
    Unit Price: Enter the provider's charge for each unit of service being requested. Do not enter the total charge unless only a single item is requested
    Description of Service: Enter a description of each service requested, including brand name and model number, if applicable
    Amount Authorized: DO NOT COMPLETE. This field will be completed by Medicaid Division Staff if required
11. **Name of Prescribing Practitioner:** Enter the full name of the practitioner who prescribed the service
12. **Prescribing Practitioner's NPI:** Enter the 10-digit National Provider Identifier (NPI) of the prescribing practitioner
13. **Client in Nursing Facility/ICF/DD:** Indicate if the client was residing in a nursing facility or ICF/DD on the date of service
14. **Rental Items Only:** On the line corresponding to the rental item requested in Item 9, enter the purchase price, the date the rental item was initially provided to the client and whether the item was new or used when delivered
15. **Diagnosis:** Enter the appropriate diagnosis for the ICD Version Indicator selected in Item 14
16. **Date Requested:** For purchases – Enter the date that the item will be delivered if prior authorization is required before the item can be used. For rentals – Enter the rental period being requested. For other items – Enter the date service requested.
17. **Requesting Provider's Signature:** Enter the signature of the provider or the provider's authorized representative
18. **Date of Request:** Enter the date the provider submits the request
19. **Comments:** For Medicaid Use Only
20. **Signature of Authorizing Agent:** Signed by Authorizing Agent, Date and Decision

Distribution: DMEPOS ONLY – Submit the completed Form MS-77 with the required documentation of medical necessity to the Departments Utilization Management Provider. You will receive notification from the Utilization Management Provider. **INJECTABLE MEDICATION ONLY –** Fax requests to 402-471 9103 or email requests to: DHHS.MedicaidPharmacyUnit@nebraska.gov. You will receive notification from the Department.