LOUISIANA
DEPARTMENT OF HEALTH
Aging and Adult Services

# REQUEST FOR PAYMENT/OVERRIDE FORM

## Section I: Demographic and Support Coordination Agency (SCA) Information

Participant Name: ______________________ Medicaid # (13 digits): ____________ DOB: ____________

SCA Name: ______________________ SCA Phone: ____________ SCA Fax: ____________

SCA Contact: ______________________ SCA E-mail Address: ______________________

Population: ☐ Adult Day HealthCare (ADHC) Waiver ☐ Community Choices Waiver (CCW)

## Section II: Reason for Request

Reason for Request: ______________________________________________
______________________________________________

## Section III: Prior Authorization (PA) Request

PA Request Begin Date: ____________ End Date: ____________ Date SCA Received Medicaid Decision Notice (initials only): ____________

**ONLY ATTACH DOCUMENTS NECESSARY TO JUSTIFY REQUEST.** *(OAAS may request additional information.)*

Check the appropriate boxes below that contains documents that are attached:

☐ Approved POC ☐ Progress Notes/Typed Chronology ☐ CMS 1500 Other: ______________________

## Section IV: OAAS Review and Signature *TO BE COMPLETED BY OAAS*

☐ APPROVED ☐ DENIED ☐ RETURNED (See Reason Below)

Notes: ______________________ If denied or returned, please provide reason below:
______________________ ______________________
______________________ ______________________

OAAS Authorized Reviewer Signature: ______________________ Date: ____________

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# INSTRUCTIONS FOR COMPLETING REQUEST FOR PAYMENT/OVERRIDE FORM

Complete this form to request payment of claims denied by Molina. **Do not leave any blanks. OAAS will not override timely filing limits.** It is the responsibility of each agency to reconcile all billings in a timely manner. OAAS requires a maximum of forty-five (45) calendar days to process all requests after receipt of all required documentation. Any request not containing the necessary information will be returned as incomplete and considered not received.

**Complete Section I: Demographic and SCA Information**

**Complete Section II: Reason for Request**

Indicate the reason for the denied claim request**, be specific**.
Include the 3 digit Medicaid claim denial code from the Remittance Advice (RA).

**Complete Section III: PA Request Dates**

Indicate the start and end date for the period of reimbursement you are requesting.

**For OAAS Regional Office (RO) : Complete Section IV: OAAS Review and Signature Section**

SCA will submit completed form and supporting documentation to OAAS R.O. for approval and signature.
If denied or returned, OAAS RO will give a detailed explanation for rejection, using an extra sheet if necessary, and email to the SCA.
If approved, OAAS RO will e-mail a copy to the SCA and a copy to SRI for payment.