Print Form

THE DIVISION OF MEDICAL ASSISTANCE

Home and Community Care Section

CAP/DA PRIOR APPROVAL RETRO REQUEST

[Date]

From: [Case Manager]
[Agency Name]
[Contact Information]

Subject: Prior Approval Retro Request

Beneficiary:_____

MID #: _____

Reason for CAP/DA Retro Request: _____

Date of prior approval denial by fiscal contractor: _____/_____/_____

Prior Approval Number: _____

LOC: _____

Date of the approval LOC: _____/_____/_____

Brief explanation of occurrence: _____

Enclosure (s):

- ☐ Original denied FL-2
- ☐ Approved FL-2
- ☐ Signature page of original assessment that corresponds to the original denied LOC
- ☐ Signature page of the approved POC

Sincerely,
[Name]