REQUEST FOR HCPCS CODE ADDITION
MEDICAID HOME HEALTH FEE SCHEDULE

North Carolina
Department of Health and Human Services
DIVISION OF MEDICAL ASSISTANCE

PROVIDER NAME/ADDRESS:		**Contact Person**		
		Phone Number		
		Provider Number		**Date Submitted**
1.	**Name of item or supply**		**Manufacturer**	
	Provide a brief description			
	Procedure (CPT or HCPCS) code. *(Indicate if there is no HCPCS code for the item)*			
2	**Can an existing HCPCS code from the fee schedule cover this item?** *(circle)* **YES NO**			
	Explain			
3	**Did this item replace another supply previously used for the medical condition?** *(circle)* **YES NO**			
	If yes, explain reason for change *(examples: Is it less expensive to use the packaged item? Is there potential to alleviate an exacerbation of the patient's condition?, etc.)*			
4	**a. Diagnostic indication(s).**			
	b. Duration and frequency of use.			
	c. Proposed advantages of the new care, service, or supply.			
5	**a. Estimates of charges for the requested coverage** *(charge billed to Medicaid by your agency)*		**b. Actual cost and source**	
6	**Does Medicare and/or another insurance company cover this?** *(circle)* **YES NO** **(Attach verification, if available)**			
7	**Extent to which the requested coverage is currently in use in North Carolina (if known)**			
8	**Attach any supporting data from research studies, peer-reviewed journals, etc. Attachments?** (*circle)* **YES NO**			

Submit completed form with attachments to Hospice/Home Health Program Consultant, DMA Clinical Policy and Programs, 2501 Mail Service Center, Raleigh, NC 27699-2501