KANSAS HEALTH ADVANTAGE

Auth. Submission Fax: (844) 363-7493

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage

AUTHORIZATION REQUEST

Member Name _____ DOB _____ Member ID _____

Nursing Facility _____

Requesting Provider / Type _____ NPI: _____

Phone #: _____ Fax #: _____

Primary Diagnosis _____

Diagnoses (ICD-10 Codes) Related to Auth Request _____

Servicing Provider/Facility: _____ Tax ID #: _____

Servicing Provider Phone #: _____ Servicing Provider Fax #: _____

(Include all Clinical Documentation with request)

☐ SNF (After Discharge) ☐ Inpatient Admit ☐ Behaviorial Health ☐ Outpatient Services ☐ SIP (Skill in Place) Start Date _____

☐ Home Health ☐ DME: Rental or Purchase (circle one) Office Visit: ☐ New Patient ☐ Follow/up

☐ Diagnostic Testing or Procedure (List Type and CPT code) _____

List Provider/Facility: _____

Scheduled Date for Services (if Scheduled) _____

CPT Codes & Quantities: _____

THERAPY REQUEST

REQUEST FOR PART B THERAPY SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

Request for ☐ PT ☐ OT ☐ ST ☐ Other _____

☐ Therapy Treatment Plan ☐ Additional Therapy Days ☐ In Progress

Start date of Services: _____ Date of Initial Evaluation: _____ Date of Last Exam _____

# of PT Therapy: _____ _____ Times per week For _____ weeks

# of OT Therapy: _____ _____ Times per week For _____ weeks

# of ST Therapy: _____ _____ Times per week For _____ weeks

List of CPT Codes: _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** Authorization Requests (properly completed and includes supporting medical record documentation, when required) from a PCP or Plan NP are completed within 14 days per the CMS guidelines. Our goal is 5-7 days.

☐ **Expedited Authorization (Must Read and SIGN):** By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, or health in serious jeopardy.

SIGNATURE: _____ Date Completed: _____

Name of Person Completing this form: _____

Notification will be faxed upon determination. Please complete the following for notification of decision.

Who is Receiving Authorization Notification FAX: _____

Contact #: Authorization Notification FAX:

This authorization is **NOT** a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.