

Kentucky Medicaid Therapy Prior Authorization Request Form Instructions

Provider Information Section:

Complete the Provider Name and Number, Phone and Fax Numbers and Contact Person. The contact person noted should be the best person to answer any questions about the fax. Provider address is optional.

Member Information Section:

Complete Member Name and Medicaid Number, DOB and Age. The Member address is optional. Please list applicable Diagnosis Code Description and ICD 10 Code.

Services Section:

List the therapy discipline that is being requested, the total number of visits being requested, and the requested start and end date for the episode of therapy being requested. ** Specific codes do not have to be designated only the total number of visits planned for the requested authorization period.

Please address the 4 questions listed in the checklist section. Mark if this is a new PA request and denote which waiver program the individual has received therapy as a service in the past. Complete the Treatment Plan Overview designating the planned number of visits per week over how many weeks.

Notes/Additional Comments:

Please add any additional information in this section that you feel will be helpful for the reviewer to have in making the determination.

Please remember to include the current therapy order and any pertinent evaluations or treatment summaries with the request.

Requests can be faxed to 877-455-1275 or emailed to TherapyPA_Request@hpe.com If you have questions regarding a pending request, please email your question to the Therapy Request email address.

Requests should no longer be faxed or called to Carewise Health for dates of service beginning September 9, 2016.