

COMMONWEALTH OF KENTUCKY  
Cabinet for Health & Family Services  
KENTUCKY MEDICAID PROGRAM

PRIOR AUTHORIZATION FOR HEALTH-SERVICES  
INSTRUCTIONS

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**Eligibility Information:**

Please complete the form as described by the instructions listed below. **“Caution” Check The Medicaid Card.** In order for you to receive payment, the recipient must be eligible on the date of service.

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- Access KyHealth-Net at <http://www.chfs.ky.gov/dms/KyHealth.htm> and,
- Contacting the Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except Holidays.

**Saving Information:**

The form does not automatically save the entered information if filling out electronically. You must save the form to your computer.

**Mail to Address:**

Once the form is completed, please Sign and Date the form and Fax to:

For DME and EPSDT requests, fax the MAP 9 and any other documentation to SHPS at 800-907-8843. For questions about the documentation, contact the toll free number listed below.

SHPS  
9200 Shelbyville Road, Suite 100  
Louisville, KY 40222  
Telephone: 1-800-292-2392  
Fax: 1-800-807-7840  
Hours: 8:00 a.m. through 6:00 p.m.

**Note:** For EPSDT Dental, fax the MAP 9 and MAP 005 and any other documentation they may have to 877-455-1275.

Address to mail claims:  
EDS/HP  
P.O. Box 2102,  
Frankfort, KY 40602.

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**Detailed Procedures:**

<u>Item #</u>	<u>Description</u>
1.	Enter the Ten (10) digit Medicaid Assistance I.D. No.
2	Enter the Recipients Last Name.
3.	Enter the Recipients First Name.
4.	Enter the Recipients Middle Initial (M.I).
5a.	Enter the Ten (10) Digit Provider Number.
5b.	Enter the Ten (10) Digit Prescriber Number.
6a.	Enter the Provider Name, Address, and Phone Number for the provider number entered in 5a.
6b.	Enter the Prescriber Name, Address, and Phone Number for the provider number entered in 5b.
7.	Select from the drop down box the County # of Recipient Residence.
8.	Enter the Date of Delivery (if already delivered).
9.	Enter the Primary Diagnosis.
10.	Enter the Secondary Diagnosis.
11.	Enter the Date of Birth (MM/DD/YYYY).
12.	Line No. (6 lines available)
13.	Enter the Procedure/Supply Description.
14.	Enter the Procedure Supply Code.
15.	Enter the Units of Service.
16,	Enter the Usual and Customary Charges.
19.	For HCB and Model Waiver Providers, enter Approximate Total Monthly Charge.