Kentucky Medicaid
Therapy Prior Authorization Request Form

Provider Information				
Provider Name		Provider Number		
Provider Address		Facility Contact Person		
Provider Phone Number		Fax Number	Date	
Member Information				
Member Last Name	Member First Name	Medicaid Number	DOB	Age
Member Address		City	Zip Code	

Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code
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Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code

Service Requested	**# of Visits Requested**	**Start Date**	**End Date**

Form Instructions

Please complete the above information for each Medicaid member when requesting services.
Please submit clinical documentation to support medical necessity to include at minimum: therapy order (valid for 90days), treatment plan, and initial evaluation or progress notes.

All fields are required to process the Prior Authorization request. This request does not guarantee services will be authorized. (Additional information may be requested.)

Request Checklist		
1. Requested services are physician, physician assistant, advanced practice RN or psychiatrist directed	Yes ☐	No ☐
2. A. Treatment is for the maximum reduction of the effects of a physical or intellectual disability; OR B. Rehab potential with expectation for clinical/functional improvement	A ☐	B ☐
3. There is documented member adherence to home exercise program (HEP)	Yes ☐	No ☐
4. There are documented short-term goals (STG) and long-term goals (LTG)	Yes ☐	No ☐
Therapy Information		
Is this a new PA? Y/N **Individual has received therapy through _____ waiver program**		
Treatment Plan Overview	Services to be rendered: ____times per week for____ weeks.	

Notes/Additional Comments: