Kentucky Medicaid
Therapy Prior Authorization Request Form

Provider Information				
Provider Name		KY Medicaid 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
Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code
Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code

Discipline Requested	# of Visits Requested	Start Date	End Date

Form Instructions

Please complete the above information for each Medicaid member when requesting services. Submit clinical documentation to support medical necessity to include at minimum: order for therapy (must be no greater than 30 calendar days of service dates requested), treatment plan signed and dated by the referring provider, and initial evaluation and/or recertification assessment with progress summary and updated POC, also signed and dated by the referring provider.

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 /ordered	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	
Frequency and Duration:	Services to be rendered: ____times per week for____ weeks. (90 calendar days max)

Revised 7/9/2020

Notes/Additional Comments:

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