**Prior Authorization Request Form – Confidential**

Please complete this form in its entirety. Fax completed form, along with all necessary clinical information to support medical necessity review request to Kepro at 512- 975-7642. You may also request a prior authorization (PA) by contacting Kepro’s Customer Service Department at 800-634-4832.

**Request Type (Select One)** ☐Concurrent ☐Prior Authorization ☐Retrospective **Date of Request**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Provider Information** |
| Requesting/Ordering/Referring Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Requesting Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Servicing Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Servicing Provider NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Participant Information** |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Participant ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Service Type:** Select either Outpatient or Inpatient and the applicable service type below; Inpatient must include Length of Stay (LOS) start and end dates |
| ☐ **Outpatient** *Select applicable service type below* Reminder: Procedure codes must be provided on Page 2 for Outpatient procedures | ☐ **Inpatient** *Enter LOS and select applicable service type below* **LOS Start Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **LOS End Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐Home Health ☐Therapies (OT, PT, ST) ☐Home IV Therapy ☐Total Parenteral Nutrition ☐Intravenous Immunoglobin (IVIG) ☐Surgical Procedure ☐Pain Management ☐Gender Reassignment ☐Nutritional Counseling ☐Clinical Trials ☐Miscellaneous Services | ☐Inpatient Hospital ☐Skilled Nursing Services ☐LTAC ☐Inpatient Rehab ☐Gender Reassignment ☐Transplant ☐Inpatient BH Admission ☐Inpatient SA Admission ☐BH Residential Treatment Facility ☐SA Residential Treatment Facility ☐BH Partial Hospitalization ☐SA Partial Hospitalization ☐Halfway Housing ☐Group Home |
| **Diagnosis** ☐*Mark Primary Diagnosis, use additional pages as necessary* |
| Primary | Diagnosis Code | Primary | Diagnosis Code |
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| **Services Requested** *Use additional pages as necessary* |
| Modifier | Procedure Code | Requested Start Date | Requested End Date | Requested Quantity |
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| Modifier | Procedure Code | Requested Start Date | Requested End Date | Requested Quantity |
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| **Additional Comments or Information**  |
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