Kepro
Making healthcare work™

AUTHORIZATION REQUEST SUBMISSION TYPES AND TIMEFRAMES

How to request a prior authorization

- **Electronic Submission**
  - Additional benefits when requests are submitted electronically include messaging capability and updates on requests as they move through the review process.
- **Prior authorization request fax form**
  - Please note: Faxed requests are processed on a first-come, first-served basis. Providers must still access the Kepro portal to review determinations.

Submission Timeframes

- Providers have 10 business days from the date of admission/first date of service to submit a prior authorization request for most services. There are exceptions for certain service types.

- An EOB or certificate of non-coverage should be included with all authorization requests in instances where the service is denied by the primary payer for a Medicaid covered service. Submission within 10 business days from the date the Provider receives the EOB denial or certificate of non-coverage is ***strongly recommended*** to meet retrospective review guidelines.

- **The Retrospective Review Policy will be applied to requests submitted after this timeframe. Any request submission that does not meet this policy will be administratively closed and a policy denial letter generated and uploaded for download on the provider portal. Providers must access the provider portal to view the determination letter for additional information.**

Retrospective Review Policy Guidelines

- **Retrospective requests must be submitted within 365 days of the service start date and meet review guidelines when:**

  - Retroactive Medicaid- Medicaid coverage is backdated to include the date of the service

  - In instances where the Kepro system is inaccessible (this would be announced to all providers) or the provider has approved leniency from BMS due to a systems issue (e.g., computer system failure, fire etc.).