**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **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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