



CONFIDENTIAL

Intensive In-Home Prior Authorization Request Form

KePRO & DMAS now require that any Medicaid Provider submitting Prior Authorization Requests using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide a 9 digit Zip code. If you do not know your 9 digit Zip code, please visit <http://zip4.usps.com/zip4/welcome.jsp>

Fax: 1-877-OKBYFAX (877-652-9329) Phone: 1-888-827-2884

Initial Request Extension Retro Authorization Request Transfer

<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension <input type="checkbox"/> Retro Authorization Request <input type="checkbox"/> Transfer			
1) Admission Date:	2) Enrollee Last Name:	3) Enrollee First Name:	4) Enrollee Medicaid Number:
5) Requested Start Date:	6) Date of Birth (mm/dd/yyyy):	7) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	8) Provider Contact Person:
9) Provider Name:	11) Provider Address (including 9 digit Zip Code):		12) Provider Phone Number:
10) Provider NPI/API #:			13) Provider Fax Number:
14) DSM IV DIAGNOSTIC CODES: (* Required) Axis I * Axis II *	15) Current Symptoms/Behaviors: This information is to be completed utilizing PA Checklist		

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INTENSIVE IN-HOME SERVICES ELECTRONIC FAX FORM INSTRUCTIONS

Web Resources: www.dmas.kepro.org
 www.dmas.virginia.gov

This FAX submission form is required for **INTENSIVE IN-HOME SERVICES** prior authorization review.

Please ensure that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via fax for additional information.

If KePRO determines that your request meets appropriate review guidelines, the request will be “tentatively approved” and transmitted to First Health Services (FHS) for final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to you via the web-based program iEXCHANGE (<http://dmas.kepro.org>) within 24 hours of the decision.

The following will guide you through the sections of the form

Please mark with an **X** the type of request (Initial, Extension, Retro Authorization, or Transfer)
Transfer – Need last date of service from previous facility and start of care date at your facility

1) Admission Date

Enter the date the recipient was originally admitted to the service.

2) Enrollee Last Name

Enter the enrollee’s last name exactly as it appears on the Medicaid card.

3) Enrollee First Name

Enter the enrollee’s first name exactly as it appears on the Medicaid card.

4) Enrollee Medicaid ID Number

Please ensure that the enrollee’s Medicaid number is valid and contains 12 digits (This is the provider’s responsibility).

5) Requested Start Date

Enter the date the requested services are to begin

6) Date of Birth

Enter the date of birth in the MM / DD / YYYY format (for example, 02/25/2008).

7) Gender

Please mark with an **X** the appropriate gender of the recipient.

8) Provider Contact Person

Enter the primary contact person for the requesting service or provider.



9) Provider Name

Enter the name of the requesting provider.

10) Provider NPI/API Number

Enter the Provider ID number. A 10 digit number is used for Providers using their National Provider Identifier or Atypical Provider Identifier

11) Provider Address (Including 9 digit Zip code)

Enter the provider's service address

12) 9 Digit Zip Code (Required): Providers must enter their 9 digit Zip code to ensure their correct location is identified for the National Provider Identifier (NPI) number.

13) Provider Phone Number

Enter the phone number of the requesting service provider.

14) Provider Fax Number

Enter the fax number of the requesting service provider.

15) DSM IV Diagnostic Codes

Enter the appropriate DSM IV code. *Axes I and II are required codes.*

16) Current Symptoms/Behaviors

Utilize PA Checklist to provide this information.