



CONFIDENTIAL

**Community Mental Health Rehabilitative Services
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

<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:	End 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)		15) CURRENT MEDICATIONS:					
Axis I		16) SELECT PROGRAM BELOW:					
Axis II		<input type="checkbox"/> H2017 Psychosocial Rehabilitation Services		<input type="checkbox"/> H0039 Intensive Community Treatment			
Axis III		<input type="checkbox"/> H0046 Mental Health Support		<input type="checkbox"/> H0035 Therapeutic Day Treatment for Children/Adolescents			
Axis IV		<input type="checkbox"/> H0023 Mental Health Case Management		<input type="checkbox"/> H0035 Day Treatment/Partial Hospitalization for Adults			
16 a.) Please complete and attach procedure code specific "Required PA Information Checklist".							

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Enrollee Last Name:		Enrollee First Name:		Enrollee Medicaid Number:	
Number	17. Procedure Code	18. Code Description	19. Units Requested	20. Dates of Service	
				From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.				/ /	/ /
2.				/ /	/ /
3.				/ /	/ /
4.				/ /	/ /
5.				/ /	/ /
6.				/ /	/ /
7.				/ /	/ /
8.				/ /	/ /
9.				/ /	/ /
10.				/ /	/ /
11.				/ /	/ /
12.				/ /	/ /
13.				/ /	/ /
14.				/ /	/ /
15.				/ /	/ /
16.				/ /	/ /
17.				/ /	/ /
18.				/ /	/ /
21.	Contact Name:				
22.	Contact Telephone Number:				
23.	Contact Fax Number:				



COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES ELECTRONIC FAX FORM INSTRUCTIONS

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

This FAX submission form is required for **COMMUNITY MENTAL HEALTH REHABILITATIVE 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
- **9 Digit Zip Code (Required)**: Providers must enter their 9 digit Zip code to ensure that their correct location is identified for the National Provider Identifier (NPI) number

12. Provider Phone Number

- Enter the phone number of the requesting service provider

13. Provider Fax Number

- Enter the fax number of the requesting service provider

14. DSM IV Diagnostic Codes

- Enter the appropriate DSM IV code. (**Axis I required**)

15. Current Medications

- List current medications

16. Select Program Below

- Choose the program type that corresponds to your request.

16 a. Fill out and attach the corresponding "Required PA Information Checklist" for any procedure code you are requesting.

- These can be found under the 'Checklist' section at <http://dams.kepro.org>.



17. Procedure code:

- Enter procedure code requested (see page 1)

18. Code Description:

- Provide procedure code description (example- - H2017 Psychosocial Rehabilitation Services)

19. Units Requested:

- Enter units requested.

20. Dates of Service:

- Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date. Enter Start date and end date requested.

21. Contact Name:

- Enter the name of the person to contact if there are any questions regarding this fax form.

22. Contact Phone Number:

- Enter the fax number with the area code to respond if there are any questions/issues.

23. Contact Fax Number:

- Enter the fax number with the area code to respond if there are any questions/issues.