Kentucky Medicaid
Therapy Prior Authorization Request Form

Clear Form

Provider Information

Provider Name	KY Medicaid Provider Number	
Provider Address	Facility Contact Person	
Provider Phone Number	Fax Number	Date

Member Information

Member Last Name	Member First Name	Medicaid Number	DOB	Age 0
Member Address		City		Zip Code

Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code
Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code
Diagnosis	ICD 10 Code	Diagnosis	ICD 10 Code

Discipline Requested	# of Visits Requested	Start Date	End Date

Form Instructions

Please complete the above information for each Medicaid member when requesting services. Submit clinical documentation to support medical necessity to include at minimum: order for therapy (must be no greater than 30 calendar days of service dates requested), treatment plans, initial evaluation, and/or recertification assessment with progress summary and updated POC's, are to be signed and dated by the referring provider, another Physician, APRN, Physician Assistant, or RN within the same group.

Stamped, signed, and electronic signatures are allowed.

This request does not guarantee services will be authorized. (Additional information may be requested.)

Request Checklist		
1. Requested services are physician, physician assistant, advanced practice RN or psychiatrist directed /ordered	Yes ○	No ○
2. A. Treatment is for the maximum reduction of the effects of a physical or intellectual disability; OR B. Rehab potential with expectation for clinical/functional improvement	A ○	B ○
3. There is documented member adherence to home exercise program (HEP)	Yes ○	No ○
4. There are documented short-term goals (STG) and long-term goals (LTG)	Yes ○	No ○

Therapy Information	
Frequency and Duration:	Services to be rendered: ____times per week for____ weeks. (90 calendar days max)

Revised 6/8/2023

Notes/Additional Comments: