Map 130
(Rev. 09/11)

PRIOR AUTHORIZATION FAX-FORM

Kentucky Medicaid Home Health Services Program
FAX NUMBER: 1-800-664-5749 CALL IN: 1-800-664-5725

DATE FORM COMPLETED _____

Complete all questions. A clean form is required for each submission. Illegible and incomplete forms will not be processed. *For Supply Only, only highlighted fields are required.*

Start Date for Episode of Care:	**Type of PA:** ☐Supply Only ☐Re-Authorization ☐Modification ☐Retrospective
Has Recipient been Discharged: ☐**Yes** ☐**No**	**If Discharged, Date of Discharge:**
Reason for Discharge:	
Type of Medical Coverage: ☐Medicaid ☐Dual Eligible ☐Private Insurance (Third Party Liability)	
Is there a current PPS Medicare or Third Party (TPL) episode of care: ☐Yes ☐No If *yes and dual eligible, complete below.*	
Current PPS Medicare or Third Party (TPL) episode of care: Start Date:	End date: ☐ N/A
Map 34 Signature Date: ☐N/A	**Rejection Type**: ☐Title 18 ☐IUR
State explanation from Map 34 below or (attach copy of Map 34 to fax):	

RECIPIENT INFORMATION

Recipient Name:		
Medicaid ID #:	**Date of Birth**:	**Gender**: ☐Male ☐Female
Recipient Address:		
Parent/Guardian (If applicable**):**	**Relationship**:	

HOME HEALTH AGENCY (HHA) INFORMATION

Agency Name:	**NPI**:
Branch:	**Telephone #**: **ext**.
Requestors Name:	**Fax #**:
Contact (if different):	
Indicate if Recipient receives any of the following service(s): ☐N/A ☐ABI ☐ABI/LTC ☐ADHC ☐CDO ☐ CDO – Goods/ Services ☐CMHC ☐EPSDT ☐HCB ☐MPW ☐MFP ☐MIIW ☐SCL ☐Other (i.e. Private Grants):	
Is Recipient a resident of: ☐Group Home ☐Personal Care Home ☐Family Care Home ☐N/A	
Is Recipient Homebound: ☐Yes ☐No If **Yes, Provide documentation to validate HHA services. If No, explain justification for HHA services in lieu of outpatient service below.**	
Is Recipient able to provide self care: ☐Yes ☐No **Is there a reliable and able caregiver**: ☐Yes ☐No **If no to either question please explain below:**	

PRIMARY PHYSICIAN INFORMATION

Physician Name:	**Telephone**:
Date Recipient Last Seen by the Primary Physician:	
Primary Dx(s) ICD CM code and description:	
Secondary Dx(s) ICD CM code and description:	
Current written or verbal Physician's Order(s), date(s):or (attach signed written order/transcribed verbal order to fax):	

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Recipient Name: _____ **Recipient Medicaid ID #:** _____

HHA SERVICES-Skilled Nursing Visit, Medical Social Services, Therapies and Aide

Revenue Code	Type of Service	Frequency	# Visits Requested	Start Date	End Date

HHA DISPOSABLE MEDICAL SUPPLIES (EXCLUDE ALL ADMINISTRATIVE SUPPLIES)

HCPCS Code	Item Description	Quantity/Units	Start Date	End Date

For Supply Only: **MAP-248 completed:** ☐**Yes** ☐**No** **Start Date:** _____ **End Date:** _____
MAP-248 Physicians Signature Date (verbal or written):
(Complete above or attach copy of signed MAP-248 to fax.)

SKILLED NURSING VISITS (SNV) FOR MEDICATION MANAGEMENT

Have the following been assessed to coordinate Medication Management for the Recipient: Family Members, Primary Caregivers, Pharmacist or any other possible support assistance: ☐Yes ☐No
Request for: ☐Medi-Set Pre-fills ☐Insulin Pre-fills ☐Other**:**
Documentation for requested SNV for Medication Management:

NUTRITIONAL SUPPLEMENT

Number of meals eaten daily:	Height:	**Weight Gained (within 60 days)** ☐**Y** ☐**N**
Percent of each meal taken:	Weight:	**Weight Lost (within 60 days)** ☐**Y** ☐**N**

Clinical Supporting Documentation for: Services and Supplies Requisition, Gloves used in HHA care, Nutritional Supplements, Labs, Incontinent Supplies or other pertinent Documentation.

WOUND ASSESSMENT

WOUND DESCRIPTION:			
LOCATION:		DECUBITUS:	STAGE:
LENGTH:	DEPTH:	WIDTH:	
WOUND DESCRIPTION:			
LOCATION:		DECUBITUS:	STAGE
LENGTH:	DEPTH:	WIDTH:	

☐ **Check here if page 3 is required for additional information**

PRIOR AUTHORIZATION FAX-FORM

Kentucky Medicaid Home Health Services Program

Recipient Name: _____ **Recipient Medicaid ID #:** _____

WOUND ASSESSMENT (Cont.)

WOUND DESCRIPTION:			
LOCATION:		DECUBITUS:	STAGE:
LENGTH:	DEPTH:	WIDTH:	
WOUND DESCRIPTION:			
LOCATION:		DECUBITUS:	STAGE
LENGTH:	DEPTH:	WIDTH:	
WOUND DESCRIPTION:			
LOCATION:		DECUBITUS:	STAGE:
LENGTH:	DEPTH:	WIDTH:	
WOUND DESCRIPTION:			
LOCATION:		DECUBITUS:	STAGE
LENGTH:	DEPTH:	WIDTH:	

Other pertinent Documentation.

CLEAR FORM