Map 130
(Rev. 03/10)

# PRIOR AUTHORIZATION FAX-FORM

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

DATE FORM COMPLETED _____

**Complete all questions. Enter or check "NA" for any questions or sections that are not applicable. A clean form is required for each submission. Illegible and incomplete forms will not be processed.**

**NOTE: Pages may be copied if additional documentation is required.**

| | |
|---|---|
| **Date CMS 485 completed:** ☐ **N/A** | **Start Date for Plan of Care:** |
| **Map 248:** ☐ Y ☐ N ☐ **N/A If yes, enter the start/end dates: Start Date:** | **End Date:** |
| ☐ **Supply Only** ☐ **New Recipient** ☐ **Re-Authorization** ☐ **Modification** | |
| ☐ **Medicaid** ☐ **Medicare** ☐ **Dual Eligible** ☐ **Private Insurance** ☐ **Other Third Party**: | |
| **Current PPS Medicare or Third Party (TPL) episode of care Services/Supplies:** ☐ Y ☐ N ☐ **N/A** | |
| **Map 34 Signature Date**: ☐ **N/A** | **Rejection Type**: ☐ Title 18 ☐ IUR |
| **Explanation from MAP 34**: | |

**RECIPIENT INFORMATION**

| | | | |
|---|---|---|---|
| **Medicaid ID #**: | | **Medicare HIC ID # (**if dual eligible**)** | |
| | | | **Gender**: ☐ Male ☐ Female |
| **Last Name** | **First Name** | **M.I** | **Date of Birth** |
| **Parent/Guardian (**If applicable**):** | | | **Relationship**: |
| **Recipient or Guardian Address** | | | |
| **Telephone**: **N/A** | **County:** | **Height**: | **Weight**: |
| **Is Recipient Homebound:** ☐ Y ☐ N. **If yes, provide documentation to validate HH services. If no, explain justification for HH services in lieu of outpatient service** | | | |
| **Is recipient able to provide self care :** ☐ Y ☐ N **Is there a reliable and able caregiver:** ☐ Y ☐ N I**f no to either question, please explain** | | | |
| **Is recipient a resident of:** ☐ **Group home** ☐ **Personal care home** ☐ **Family care home** ☐ **N/A** | **If yes, provide name and telephone number of home:** | | |
| **Is recipient receiving any of the following services** ☐ EPSDT ☐ SCL Waiver ☐ Michelle P Waiver ☐ MFP ☐ HCBW ☐ Private Grants ☐ CMHC Services ☐ Adult Day Health Services ☐ **N/A** ☐ Other | | | |

**HOME HEALTH AGENCY INFORMATION**

| | | |
|---|---|---|
| **Agency Name:** | | **NPI#:** |
| **Branch:** | **Telephone #**: | **ext.** |
| **Address**: | **Fax** #: | |
| **Requestors Name:** | **Contact** (if different): | |
| **Has recipient been discharged from HH:** ☐ Y ☐ N ☐ N/A | **Discharge Date:** | |

**PRIMARY PHYSICIAN INFORMATION:**

| | | |
|---|---|---|
| **Physician Name:** | | **NPI #** |
| **Address:** | **Telephone:** | |
| **Date Recipient Last Seen by the Primary Physician:** | **Primary Dx(s)** ICD-9-CM code and description: | |
| **Secondary Dx(s)** ICD-9-CM code and description: | | |
| **Current Physician's Order(s), date(s) AS WRITTEN OR VERBAL AS GIVEN:** | | |

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# PRIOR AUTHORIZATION FAX-FORM

Kentucky Medicaid Home Health Care Services Program

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

**HH CARE SERVICES-SNV, Therapies and Aide**

| Revenue Code | Type of Service, Frequency and Expected Duration | # Visits Requested | Start Date | End Date |
|---|---|---|---|---|
| | | | | |
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| | | | | |
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| | | | | |

**HH CARE DISPOSABLE MEDICAL SUPPLIES (EXCLUDE ALL ADMINISTRATIVE SUPPLIES)**

| HCPCS Code | Item Description | Quantity/ Units | Start Date | End Date |
|---|---|---|---|---|
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| **Clinical Supporting Documentation for: Services and Supplies Requisition, Gloves used in Home Health Care, Nutritional Supplements, Incontinent Supplies or other pertinent Documentation.** |
|---|
| |

**PA REQUESTING SKILLED NURSING VISIT (SNV) FOR MEDICATION MANAGEMENT**

**Is Recipient Capable of Self Medication Management:** ☐ Y ☐ N. **If No, Has the HH Assessed the Capability of the:**
☐ **Primary Caregiver** ☐ **Family Member(s)** ☐ **Other Support Assistance** ☐ **Pharmacist**

**Physician's Order Includes Frequency and Duration of Requested SNV:** ☐ Y ☐ N
**Requested SNV:** ☐ **Every other week** ☐ **Weekly** ☐ **Monthly**

**Request for** ☐ **Medi-Planners** ☐ **Prefill Insulin** ☐ **Other:**

**Documentation for requested SNV for Medication Management:**

**WOUND ASSESSMENT**

| | | | |
|---|---|---|---|
| **WOUND DESCRIPTION**: | | | |
| LOCATION: | | DECUBITUS: | STAGE: |
| LENGTH: | DEPTH: | WIDTH: | CIRCUMFERENCE: |
| **WOUND DESCRIPTION**: | | | |
| LOCATION: | | DECUBITUS: | STAGE |
| LENGTH: | DEPTH: | WIDTH: | CIRCUMFERENCE: |