Kentucky Medicaid Therapy Prior Authorization Request Form Instructions
For Traditional or State Plan KY Medicaid Only.

Provider Information Section:
Complete the Provider Name and Number (KY Medicaid Provider #, not the NPI#), Phone and Fax Number (not necessary) and Contact Person. The contact person noted should be the best person to answer any questions about the request and the phone # for that person. Provider address is optional.

Member Information Section:
Complete Member Name and Medicaid Number, DOB and Age. The Member address is optional. Please list applicable Diagnosis Code Description and ICD 10 Code. The diagnosis we need should be what the therapist list on their treatment plan and if it is a referral for an evaluation, then the root cause medical diagnosis that caused the impairment that generated the referral. Once the evaluation is completed, then the treatment diagnosis is added along with the root cause medical diagnosis. These are the diagnosis that the therapist is treating. For example: CP G80.0 and Lack of Coordination R27.8

Discipline Requested:
This is the discipline requested, therapist (OT,PT,ST) and you can list more than one. If the member has all three disciplines treating them then can submit them at the same time, ensure the correct dates and amount of visits each discipline is requesting in their treatment plan.
Number of visits is the total for no more than 90 calendar days, this should match what the therapist recommended in their treatment plan or if it is for an evaluation then how many visits will it take for the evaluation and for how many weeks, the start date and the end date, no longer than 90 calendar days.
Example: Start date is day 1, End date is day 90.
Example: OT 24 visits 08/01/2020-10/29/2020
WE do not need CPT codes for review, just the discipline please.

Form Instructions:
This is a brief overview of the of how to complete the form and the documents needed for review. Refer to 907 KAR 8:040 for requirements of documentation or reach out to us at: therapypa_request@gainwelltechnologies.com and we will guide you.

Request Checklist
This is for you as the provider to review the documents for required information that we need for review per 907 KAR 8:040 prior to submission for review to obtain a prior authorization for services requested.

Therapy Information:
Frequency and Duration should match what the therapist recommended in the treatment plan.
Example: 2 times per week for 13 weeks

Notes/Additional Comments:
This is for anything you want to tell us that might help with review, this is NOT part of a medical record and not the place for any clinical information.

Email request and scan supportive documents for review to:
therapypa_request@gainwelltechnologies.com which is the desire mode of submission or fax to: 502-214-3560.
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