KyHealth Choices Prior Authorization Call Checklist

Prior to calling or faxing this request to prior authorize services, please complete the following information for each Medicaid member when requesting services. By completing this form our representatives will be able to process your request more quickly. We thank you for your assistance.

Clinical staff should make the Prior Authorization request.

Review the attached list to see if service requires prior authorization (which would be the letter) and add below.

All fields are required to process the Prior Authorization request.

This request does not guarantee these services will be authorized.

Member Last Name	Member First Name	Member Middle Initial	Member Medicaid ID Number
Member Address	City	Zip Code	Responsible Party for Member Under Age of 18.
Ordering Provider Name		Ordering Provider's Medicaid Number (non-Medicaid providers should enter license number and state)	
Ordering Provider Contact Person Name		Ordering Provider Contact Person Phone # ( )	
Facility Name		Facility's Medicaid Number	
Facility Contact Person Name		Facility Contact Person Phone # ( )	
Date(s) of Service			
Diagnosis Codes			
Clinical Criteria			
Procedure Codes			