Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593

TOTAL PARENTERAL NUTRITION

PRIOR AUTHORIZATION REQUEST

BENEFICIARY INFORMATION

Beneficiary name: _____ Date of birth: ____/____/_____

Beneficiary Medicaid ID #: _____

PROVIDER INFORMATION

Provider name: _____

Provider ID #: _____ Provider NPI #: _____

Provider contact person: _____ Phone #: _____

MEDICAL NECESSITY INFORMATION

1) Parenteral nutrition diagnosis: _____

2) Does beneficiary live at home? Yes☐ No☐ If no, where does beneficiary live? _____

3) Is home health involved with beneficiary's care? Yes☐ No☐

If so, which home health agency? _____ Phone #: _____

4) Is parenteral nutrition sole source of nutrition? Yes☐ No☐

If no, explain what other source of nutrition beneficiary is receiving and approximate number of calories derived from additional source of nutrition.

_____

_____

5) Grams of protein per day: _____ HCPC Code: _____

6) Grams of lipids per day: _____ HCPC Code: _____

7) Calories per day from TPN: _____

8) Beneficiary's weight within last 30 days: _____ Date obtained: ____/____/_____

9) What type of parenteral catheter (such as hickman, port-a-cath) does the beneficiary have in place?

_____

10) Status of medical condition (such as stable, declining) _____

11) Length of time anticipated for use of TPN: _____

12) How often and what type of labs are being done? _____

Fax completed forms to 1-800-913-2229 or 785-274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If a case has been started and the information requested is not received within 15 working days, the case will be denied.
Prior Authorization: 1-800-933-6593

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