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

General Prior Authorization Request

Provider # _____ **Provider NPI #** _____

Provider Name, Address & Phone #

PA does not guarantee eligibility.

If service is not covered by Medicaid/MediKan, then PA is void.

PA does not override PCCM referral limitation.

PA does not override program limitations.

I. GENERAL BENEFICIARY INFORMATION

Beneficiary Medicaid ID #	Beneficiary name (last, first, MI)	Date of birth

Diagnosis description

II. SERVICE INFORMATION

OFFICE USE ONLY

Ref No	Procedure Code	From Date	Through Date	Description of Service/Item	Qty or Units Requested	Amount to be Charged	Approved	Denied	Approved Amount
1									
2									
3									
4									
5									
6									
7									
8									

FOR VISION USE ONLY

Date of last examination	Prescription
	DIST: R☐ L☐ ADD: R☐ L☐

Detailed explanation of medical necessity for services/equipment/procedure/prosthesis. (Include letter of Medical Necessity if applicable.)

Provider signature:_____ Date: _____

FOR OFFICE USE ONLY
Consultant comments:

Signature:_____ Date: _____

Completed form should be faxed to 1-800-913-2229.
THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Prior Authorization: 1-800-933-6593 **Prior Authorization Fax: 1-800-913-2229 or 785-274-5956**

Revised 10.2017

General Prior Authorization Request Instructions

All required fields must be completed on the General Prior Authorization Request form. **Please note all limitations identified in the upper right-hand corner of the form.** Do not enter information in the section labeled FOR OFFICE USE ONLY. This area is for the fiscal agent and Kansas Department for Children and Families (DCF) use only.

Provider #	**Required –** Enter the 10-digit Kansas Medical Assistance Program (KMAP) provider number of the provider requesting the prior authorization (PA).
Provider NPI #	**Required –** Enter the National Provider Identifier of the provider requesting the PA.
Provider name, **address & phone number**	**Required –** Enter the name, address, and telephone number of the provider requesting the PA.
Beneficiary Medicaid ID #	**Required –** Enter the beneficiary's 11-digit number from his or her State of Kansas Medical Card.
Beneficiary name	**Required –** Enter the beneficiary's name (last, first, middle initial).
Date of birth	**Required –** Enter the beneficiary's date of birth as month, day, and year (such as 10/01/57).
Diagnosis description	**Required –** Describe the primary diagnosis for the service(s) being requested.

The following six fields are part of a detail line which occurs up to eight times:

Procedure code	**Required –** Enter the procedure code that identifies the specific service being requested.
From date	**Required –** Enter the earliest day this service will be approved to be provided.
Through date	**Required –** Enter the last day this service will be approved to be provided.
Description of service/item	**Required –** Describe the service to be authorized.
Qty or units requested	**Required –** Enter the number of units being requested.
Amount to be charged	**Required –** Enter the dollar amount (total) being requested.

General Prior Authorization Request Instructions

The following two fields are for vision PAs only:

Date of last examination	**Required –** Enter the date of the beneficiary's last vision examination.
Previous prescription	**Required –** DIST: Enter the distance for the right and left eye.
	Required – ADD: Enter the additional prescription for the right and left eye.
Detailed explanation of medical necessity	**Required –** Fully describe the medical necessity for the service being requested. Additional documentation may be attached to the form if more space is needed.
Provider signature & date	**Required –** The provider must sign and date the form.

Send completed form to:

Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571