



# INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This FAX submission form is required for faxed outpatient Initial Certification and Recertification. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on KEPRO forms can be entered.

If KEPRO determines that your request meets appropriate coverage criteria guidelines the request will be “tentatively approved” and transmitted to the ODM MITS System for the final approval. Final approval is contingent upon passing remaining Member and provider eligibility/enrollment edits. The Prior Authorization number provided by the MITS system will be available to providers registered on the web-based program Atrezzo Connect.

1. **Request type:** Place a **V** or **X** in the appropriate box.
  - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
  - **Recertification:** A request for continued services (items) beyond the expiration of the previous Service Authorization would be a recertification request.
  - **Change:** a change to a previously approved request; If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a “change” request for any item that has been pended.
  - **Cancel:** Use to cancel all or some of the items under one Service Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Member number.
  - **Transfers:** **a) Provider:** Use when requesting a transfer of care between providers or a transfer of a providers NPI number.
2. **Date of Request:** The date you are submitting the Service Authorization request.
3. **Review Type:** Place a **V** or **X** in the appropriate box.
4. **Member Medicaid ID Number:** It is the provider’s responsibility to ensure the Member’s Medicaid number is valid. This should contain 12 numbers.
5. **Member Last Name:** Enter the Member’s last name exactly as it appears on the Medicaid card.
6. **Member First Name:** Enter the Member’s first name exactly as it appears on the Medicaid card.
7. **Date of Birth:** Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).

8. **Gender:** Please place a **√** or **X** to indicate the sex of the member.
9. **a. NPI/API Requesting/Service Provider Name and ID Number:** Enter the requesting/service provider name and ID number, national provider identifier or atypical provider identifier.
10. **Treatment Setting:** Place a **√** or **X** to indicate the place of service.
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). For dates of service 10/1/15 and beyond please use the appropriate ICD-10 code.
12. **a. NPI/API Referring Provider Name and ID Number:** Enter the referring provider name and ID number, national provider identifier or atypical provider identifier for the provider requesting the service.
13. **a. NPI/API Ordering Provider Name and ID Number:** Enter the ordering physician name and ID number, national provider identifier or atypical provider identifier for the provider requesting the service.
14. **Member Information:** Provide the name of the responsible party of the Member (if applicable) and the relationship to the Member”.
15. **Please submit the following documentation with this request:**
  - Prescription or orders that are signed by the attending physician
  - Complete diagnosis list
  - Medical History
  - Level of care needs based on medical necessity
  - Physician certification of Medical Necessity (JFS 07137)
  - If Member is currently received any State Plan Services, please include:
    - Last 3 visits of the visit notes
    - Current Signed Doctor Orders (485)
    - Nursing Assessment completed by RN

**NOTE\*\*Please ensure that all documentation is legible**
16. **HCPCS/CPT/Revenue Code:** Provide the CPT procedure code.
  - **G0151-Physical Therapy**
  - **G0152-Occupational Therapy**
  - **G0153-Speech Therapy**
  - **G0299-Skilled Home Health Nursing (RN)**
  - **G0300-Skilled Home Health Nursing (LPN)**
  - **G01556-Home Health Aide**
17. **Code Description:** Provide the HCPCS/CPT/Revenue procedure code description
18. **Modifiers (if applicable):** Enter up to four (4) modifiers as applicable.
19. **Units Requested:** Based on physician’s orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of Milliman/ODM criteria will be extremely helpful.
20. **Frequency:** Enter Frequency usage of Service requested
21. **Total Dollars Requested:** Enter the dollar amount requested for items listed for the entire date range requested.

22. **Dates of Service:** Indicate the planned service dates using the mm/dd/yyyy format. The From and Through date must be completed even if they are the same date.
23. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form.
24. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
25. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a need to request additional information.

**\*Note: Incomplete data may result in the request being denied. It is very important that this form be completed as thoroughly as possible with the pertinent medical/clinical information. The purpose of Prior Authorization is to validate that the service being requested is medically necessary and meets ODM criteria for reimbursement. Prior Authorization does not automatically guarantee payment for the service.**