Prior Authorization Request Form – Confidential

*If you are a registered user for the provider web portal, please log on to submit your review.

Please complete this form in its entirety. Fax completed form, along with all necessary clinical information to support medical necessity to Kepro at **1-888-204-0377**.

Request Type (Select One) ☐Prior Authorization ☐Retrospective

Date of Request: _____

Provider Information* all fields required
Requesting Provider Name: _____
Requesting Provider NPI: _____
Contact Person Name: _____
Contact Person Phone: _____ Fax:_____
Servicing/Billing Provider Name: _____
Servicing/Billing Provider NPI: _____*Medicaid #_____
Ordering Provider Name: _____
Ordering Provider NPI: _____*Medicaid #_____
Member (Consumer) Information* all fields required
First Name: _____
Last Name: _____
Medicaid ID: _____
Date of Birth: _____
Service Type: Advanced Diagnostic Imaging requests for fee-for service Medicaid recipients. If your patient is enrolled in the MississippiCAN program, please contact the respective program.
Diagnosis ☐*Mark Primary Diagnosis, use additional pages as necessary*

Primary	Diagnosis Code	Primary	Diagnosis Code
☐		☐	
☐		☐	

Services Requested *Use additional pages as necessary* **SERVICE DATE**: _____

Procedure Code	Code Description	Requested Quantity = 1 depending on extremity

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Additional Comments or Information

Medicaid Disclaimer

Kepro Certification Determination does not guarantee Medicaid payment for services or the amount of payment for services. Eligibility and payment of Medicaid Services are subject to all terms and limitations of the Medicaid Program.

☐ I have read and understand the above Medicaid Disclaimer.

Signature of person submitting request via fax _____Phone:_____

Remember to attach the following to items:

☐ copy of Physician Order

☐ Most recent clinical evaluation related to the physician order to support medical necessity (Please only include History & Physical, Assessment and Plans. Do not include demographic information pages or registration and consent information)

☐ copy or documentation of previous imaging studies related to the stated diagnosis