Oregon Medicaid Prior Authorization Request

KF-005

Outpatient Rehab, Community Habilitation, or ABA Behavioral Health Services

Send completed requests to KEPRO via one of the following methods:

☐ FAX to: 1-844-673-8034

☐ Send via secure email to: OR1915i@kepro.com

☐ Postal Mail to: 1750 Blankenship Road
Suite 425
West Linn, Oregon 97068

Only use this form to request authorization of outpatient rehabilitation, community habilitation or applied behavioral health analysis (ABA) services.

☐ Mental/Behavioral Health Assessment signed by QMHP within 1 year of service start date for current authorization.

☐ Mental Health treatment plan (ISSP) signed by QMHP or higher for new provider, signed by Licensed Medical Provider for yearly updates. Must be within 1 year of authorization start date.

☐ Submission must be within 30 days (before or after) of authorization start date.

***Please provide a fax number that KEPRO can send correspondence to.**

MEMBER INFORMATION	
Last Name:	First Name:
Date of Birth:	Medicaid ID (*prime number*):
Social Security Number:	Primary ICD-10 Diagnosis Code:

REQUEST INFORMATION		
This request is for (*select one*): ☐ Initial Request	☐ Reauthorization	
Behavioral Health Program Name:	Date of Admission (*MM/DD/YYYY*):	
Referring Provider MCD Number:	Rendering Provider MCD Number:	
Number of Units Requested (*over full duration*):	Level of Care: AFH ☐ RTH ☐ RTF ☐ SRTF ☐ Home ☐	
Dates of Service: From (*MM/DD/YYYY*):	To (MM/DD/YYY):	

SERVICES REQUESTED				
Description	Procedure Code	Requested Start Date	Requested End Date	Number of Units or Dollar Amount

SIGNATURES

By signing below, the Community Mental Health Program (CMHP) and Mental Health Organization (MHO) or Coordinated Care Organization (CCO) verify that they have reviewed the above services and recommend them for this member.

_____	_____	_____
CMHP representative signature	Name and title	Date
_____	_____	_____
MCO/CCO representative signature	Name and title	Date

Save As Print Clear Form

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