Oklahoma HealthCare Authority

Therapy Prior Authorization Request Form

MEDICAL RECORDS ARE REQUIRED WITH THIS FORM

Documentation must be uploaded thru the Provider Portal

Service Type (check one only*): _____ Physical Therapy (PT)
_____ Occupational Therapy (OT)
_____ Speech (ST)

Separate authorization requests are required for each Type of Service.

MEMBER INFORMATION:

Name: _____ Date of Birth: _____

ID Number: _____ Male: _____ Female: _____

REFERRING PROVIDER:

Name: _____

NPI: _____

OHCA ID: _____

Phone: _____ Fax: _____

Address: _____

RENDERING PROVIDER:

Name: _____

Office Contact: _____

NPI: _____

OHCA ID: _____

Phone: _____ Fax: _____

Address: _____

DIAGNOSES: Code _____, Code _____, Code _____, Code _____

REQUESTED SERVICE INFORMATION:

For Speech, what primary language is spoken by patient in home setting? _____

Can speech therapist evaluate and treat in patient's primary spoken language? _____ Yes _____ No

Have you previously serviced this member? _____ Yes _____No

If Yes: How many units previously approved? _____ How many units Used? _____

REQUESTED SERVICES:

Requested Date Span: From _____ To _____

Anticipated Number of Visits: _____ Duration of Session (in minutes): _____

	CODE	UNITS	MODIFIERS			
A.	_____	_____	_____	_____	_____	_____
B.	_____	_____	_____	_____	_____	_____
C.	_____	_____	_____	_____	_____	_____
D.	_____	_____	_____	_____	_____	_____
E.	_____	_____	_____	_____	_____	_____
F.	_____	_____	_____	_____	_____	_____
G.	_____	_____	_____	_____	_____	_____
H.	_____	_____	_____	_____	_____	_____

Submission of this form, without complete medical records will limit the ability to administer prior authorizations and may result in a cancellation/denial. Please include the following: 1) Evaluation **2)** Parental Consent Form SC-15 **3)** Signed and dated provider prescription/order **4)** Change of Provider Form SC-16 if applicable

OHCA Approved - 05/16/2017