STATE OF OKLAHOMA
Oklahoma Health Care Authority
Prior Authorization Request

☐ Initial Request ☐ Additional Documentation
☐ Amended ☐ Photos/Videos Included

SECTION I

Prescribing Physician No.: ____________________

NPI / ZIP+4 ____________________

Physician Name: ____________________

Phone: (   ) ____________________

Signature: ____________________ Date: __________

SECTION II

Member RID: ____________________

Member Name: ____________________

Date of Birth: ____________________

Parent/Guardian: ____________________

Address: ____________________

City/State/Zip: ____________________ Phone: (   ) __________

SECTION III

Estimated Length of Treatment: ____________________ Diagnosis Code(s): ____________________

Physician's Prescription: ____________________

SECTION IV

Servicing Prov. No. & Loc.: ____________________

NPI / ZIP+4: ____________________

Phone: (   ) __________ Fax: (   ) __________

Provider Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Signature of Servicing Prov.: ____________________ Date: __________

SECTION V

Date Span of Service From: ____________________

To: ____________________

Assignment Code (Select from below): ____________________

(01) Home Health	(08) Audiology	(26) Clinic
(02) Hospital IP Facility or Hospital IP Physician	(12) DME	(37) Hospice
(03) Hospital OP	(17) Vision Care	(40) High Risk OB
(04) Physician	(21) PD Nursing	(46) Sleep Studies
(06) Transplant	(25) Lab and X-Ray	

SECTION VI - Do Not Skip Lines or PA will be Cancelled

LINE ITEM	CPT, ICD or HCPCS Code	MODIFIER	DESCRIPTION (Must Be On One Line)	TOTAL UNITS FOR DATE SPAN	TOTAL BILLED CHARGES
A					
B					
C					
D					
E					
F					
G					
H					
I					
J					
K					
L					

FORWARD TO: Attn: Prior Authorization, 4345 N Lincoln, Oklahoma City, OK 73105
OR FAX: (405) 702-9080 Toll Free: 1-866-574-4991