STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PRIOR AUTHORIZATION REQUEST

Section I PCP/CM( )

Prescribing Provider No. ______________________

Phone ( ) ______________________

Signature ______________________

Section II

Client ID No. ______________________

DOB ______________________

Name ______________________

Address ______________________

City/State/Zip ______________________

Section III

Estimated Length of Treatment: ______________________ Diagnosis: ______________________

Physician's Recommendations:

Clinical statement by prescribing provider: Medical justification for services requested (attach any plan of treatment, progress notes, CMN, invoices, etc., as needed).

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Section IV

Rendering Provider No. (Loc.) ______________________ ( )

Phone ( ) ______________________

Fax ( ) ______________________

Name ______________________

Address ______________________

City/State/Zip ______________________

Section V

Date of Service (MMDDCCYY) ______________________

Assignment Code (select from below) ______________________

(01) Home Health	(07) TRANS	(13) PT	(19) Phar
(02) Hospital IP	(08) Audiology	(14) RT	(20) Room & Board
(03) Hospital OP	(09) Speech	(15) Dental	(21) Lab & X-Ray
(04) Physician	(10) Behavioral Health	(16) OD	(22) Clinic
(05) Rehab	(11) DME	(17) Podiatry	(23) Vision Care
(06) Transplant	(12) OT	(18) Chiro	(24) Spec. Nursing

Section VI

LINE ITEM	PROCEDURE CODE	MODIFIER	DESCRIPTION	UNITS	PRICE/DOLLARS
A					
B					
C					
D					
E					
F					
G					
H					
I					
J					

Signature of Rendering Provider ______________________ Date ______________________

FORWARD TO: OHCA, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, OK 73105