

Oklahoma Health Care Authority STATE OF OKLAHOMA Oklahoma Health Care Authority Prior Authorization Request **Prior Authorization Request**

| Initial Request | Additional Documentation |
|-----------------|--------------------------|
| Amended | Photos/Videos Included |

| SECTION I Prescribing Physician No.: NPI / ZIP+4 Physician Name: Phone: Signature: SECTION III Estimated Length of Treatment: | | | | | Member Name: Date of Birth: Parent/Guardian: Address: City/State/Zip: | | Phone: () | |
|---|---|-----|----------|-------------------------|---|---|-----------|---|
| | | | | | | | | |
| No. & L NPI / ZI Phone: Provide Addres City/Sta Signatu Servici | ng Prov. oc.: P+4: er Name: s: ate/Zip: ure of ng Prov.: | |) | Fax: () Date: | Ass (01) (02) or H (03) (04) | CTION V e Span of Service signment Code (Select Home Health Hospital IP Facility Hospital IP Physician Hospital OP Physician Transplant | To: | (37) Hospice e (40) High Risk OB g (46) Sleep Studies |
| LINE ITEM | E CPT, ICD or DESCRIPT | | | RIPTION On One Line) | | TOTAL UNITS FOR | TOTAL | |
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OHCA Revised: 10/04/2017 HCA-12A