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 ID: _____

Member Name: _____

Date of Birth: _____

Parent/Guardian: _____

Address: _____

City/State/Zip: _____ Phone: ( ) _____

SECTION III

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

Physician's Prescription: _____

Does Member Receive: ☐ IFSP/Sooner Start ☐ IEP (Please attach a copy of IFSP or IED, if applicable.) ☐ WIC

Description: _____

SECTION IV

Rendering Prov. No. & Loc.: _____

NPI / ZIP+4: _____

Phone: ( ) _____ Fax: ( ) _____

Provider Name: _____

Address: _____

City/State/Zip: _____

Signature of Rendering Prov.: _____ Date: _____

SECTION V

Date Span of Service From: _____

To: _____

Assignment Code (Select from below): _____

(01) Home Health	(08) Audiology	(17) Vision Care
(02) Hospital IP	(09) Speech	(21) PD Nursing
(03) Hospital OP	(12) DME	(37) Hospice
(04) Physician	(13) OT	(40) High Risk OB
(06) Transplant	(14) PT	

SECTION VI

LINE ITEM	PROCEDURE CODE	MODIFIER	DESCRIPTION	TOTAL UNITS FOR DATE SPAN	TOTAL BILLED CHARGES
A					
B					
C					
D					
E					
F					
G					
H					
I					
J					
K					
L					