Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Kentucky Prior Authorization Form (MAP-9) Instructions

Please see the detailed procedures for each MAP-9 form data element highlighted and numbered in red below with details in the associated table:

Member Information

Managed Care Organization 1
Check the box in which the member is Enrolled

☐ Aetna Better Health of KY

☐ Humana Healthy Horizons in Kentucky Healthcare

☐ Passport Health Plan by Molina

☐ United Healthcare Community Plan

☐ WellCare of Kentucky

Request Type – ***Select all that apply*** 2

☐ Expedited *(Requires immediate attention)*

☐ Urgent *(Requires care within 24-48 hours)*

☐ Non-Urgent (*Routine*)

☐ Initial - Pre-Service

☐ Concurrent – During Service

☐ Retrospective – Post-Service

Date of Request *(mm/dd/yyyy)* 3

Member Name *(First, Middle Initial, Last)* 4

Date of Birth *(mm/dd/yyyy)* 5

Member Medicaid ID # 6

Member MCO ID # 7

Member PCP 8

Member Phone # 9

Is Member Pregnant? ☐ Yes ☐ No ☐ Not Applicab 10

Work-Related Injury? ☐ Yes ☐ No 11

Does Member Have Other Health Insurance? ☐ Yes ☐ No
Insurer: _____
Medicare? ☐ Part A ☐ Part B 12

Motor Vehicle Accident-Related Injury? ☐ Yes ☐ No 13

Provider Information

Servicing Provider/Agency Name 14

Provider/Agency Service Location (Street, City, State, Zip Code) 15

Provider NPI # 16

Provider Tax ID # 17

Phone # 18

Fax # 19

Any Supporting Documents Included? ☐ Yes ☐ No 20

Number of Documents 21

Facility Location (Address, City, State, Zip Code) 22

Facility NPI 23

Facility Tax ID # 24

Phone # 25

Fax # 26

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Type of Service Requested
Not all plans require PAs for the same services. Check with the particular Plan before submitting. 27

☐ Behavioral Health	☐ Behavioral Health – Inpatient	☐ MSEA (DME) – Purchase	☐ MSEA (DME) – Rental
☐ Occupational Therapy	☐ Physical Therapy	☐ Speech Therapy	☐ Inhalation Therapy
☐ EPDST	☐ Home Health	☐ Surgical – Inpatient	☐ Surgical – Outpatient
☐ Private Duty Nursing	☐ Case Management	☐ Medical Care – Inpatient	☐ Medical Care – Outpatient
☐ Hospice	☐ Observation	☐ Radiology	☐ Vision/Optometry
☐ Dental Care	☐ Oral Surgery	☐ Weight Loss Surgery	☐ Maternity
☐ Substance Abuse Treatment	☐ Other: _____		

Clinical Information
Request MUST include medical documentation to be reviewed for medical necessity.

Primary ICD-10 Code _____ 28 **Description** _____ 29

Procedure/ Service Codes 30	Diagnosis Code 31	Requested Service 32	Units Requested 33	Place of Service 34	Dates of Service: Start	Dates of Service: Stop 35

Additional Information: 36

This form Completed By _____ 37 _____ **Phone #** _____ 38 _____

Item #	Description/Direction
1- Managed Care Organization (MCO)	Check the box of the MCO in which the member is enrolled.
2- Request Type	Check all boxes that apply. The options include Expedited (Requires immediate attention), Urgent (Requires care within 24-48 hours), Non-Urgent (Routine), Initial-Pre-Service, Concurrent-During Service, and Retrospective-Post-Service.
3- Date of Request	Enter the date in which this request is being made.
4- Member Name	Enter the member's first, middle initial, and last legal name.
5- Date of Birth	Enter the member's Date of Birth (MM/DD/YYYY).
6- Member Medicaid ID #	Enter the member's 10-digit Medicaid Assistance Identification Number (I.D.).
7- Member MCO ID #	Enter the member's 10-digit MCO Identification Number.
8- Member PCP	Enter the member's assigned Primary Care Physician (PCP).
9- Member Phone #	Enter the member's primary phone number.
10- Is Member Pregnant?	Check the appropriate box for the member: 'Yes', 'No', or 'Not Applicable'.
11- Work Related Injury?	Check the appropriate box for the member: 'Yes' or 'No'.
12- Does Member Have Other Insurance?	Check the appropriate box for the member: 'Yes' or No'. If 'Yes' is checked, enter the member's additional Insurer name. If the additional Insurer is Medicare, check the 'Yes' box to the question "Medicare?". If the additional Insurer is not Medicare, check the 'No' box to the question "Medicare?" and enter the other Insurer's name on the line above.
13- Motor Vehicle Accident-Related Injury?	Check the appropriate box for the member of either'Yes' or 'No'.
14- Servicing Provider/Agency Name	Enter the servicing provider's first and last name or agency name, if appropriate.
15- Provider/Agency Service Location (Street, City, State, Zip Code)	Enter the above entered provider or agency's service location including the street, city, state, and zip code.
16- Provider NPI #	Enter the servicing provider's National Provider Identifier (NPI) 10-digit number.
17- Provider Tax ID #	Enter the servicing provider's 9-digit tax identification number.
18- Phone #	Enter the servicing provider's phone number.
19- Fax #	Enter the servicing provider's fax number.
20- Any Supporting Documents Included?	Check the appropriate box of either 'Yes' or 'No' if the provider is including any supporting documentation.
21- Number of Documents	Enter the number of documents that are included, if applicable. If 'No' is checked for the question above, leave this cell blank.
22- Facility Location (Street, City, State, Zip Code)	Enter the provider's facility's location including street, city, state, and zip code.
23- Facility NPI #	Enter the facility's 10-digit NPI number.
24- Facility Tax ID #	Enter the facility's 9-digit tax identification number.
25- Phone #	Enter the facility's phone number.
26- Fax #	Enter the facility's fax number.
27- Type of Service Requested	Check the type of service being requested.
28- Primary ICD-10 Code	Enter the primary International Classification of Disease (ICD)-10 code.
29- Description	Enter a description of the above ICD-10 code.
30- Procedure/Service Code	Enter all procedure/service codes.
31- Diagnosis Code	Enter all diagnosis codes.
32- Requested Service	Enter what the requested service for each code is.
33- Units/Visits Requested	Enter the number of units or visits being requested.
34- Place of Service	Enter the two-digit code that identifies the location where the service is requested to be provided
35- Dates of Service	Enter the date(s) of service the service will be rendered.

36- Additional Information	Enter any additional information pertaining to the request not captured in the above fields.
37- This Form Completed By	Enter the first and last name of the individual completing this form.
38- Phone #	Enter the individual completing this form's phone number.

Each of the MCO's PA submission methods are located below by: Department, Phone, Fax/Other, and Online. Please see the detailed procedures for this part of the MAP-9 form per data element highlighted and numbered in red below with details in the associated table:

Note: The pharmacy department is called out below with all MCOs listed prior to the individual MCO breakdown as all MCOs and FFS utilize the pharmacy manager MedImpact.

AETNA, HUMANA, PASSPORT, WELLCARE, UNITED HEALTHCARE			
Department	**Phone**	**Fax/other**	**Online**
Retail Pharmacy (MedImpact)	1-844-336-2676 Available 7 days per week 8a.m.-7p.m. ET (Prior Authorization Call Center) 1-800-210-7628 Available 24 hours per day, 7 days per week ET (Help Desk for assistance with Technical Issues)	1-858-357-2612 1-858-790-6060 (Appeals)	MedImpact Electronic Prior Authorization (ePA)

AETNA BETTER HEALTH OF KENTUCKY			
Department	**Phone**	**Fax/Other**	**Online**
KY Medicaid Toll Free & Aetna SKY Program	1-855-300-5528		Availity Web Portal | Aetna Medicaid Kentucky

HUMANA HEALTHY HORIZONS IN KENTUCKY			
Department	**Phone**	**Fax/Other**	**Online**
Authorizations for Medical and BH Services through Humana	1-800-444-9137	1-833-974-0059	Availity Essentials™; Kentucky Medicaid: Prior Authorization Requests - Humana

PASSPORT HEALTH PLAN BY MOLINA			
Department	**Phone**	**Fax/Other**	**Online**
Primary Phone Number	1-800-578-0775		Availity*

UNITED HEALTHCARE COMMUNITY PLAN			
Department	**Phone**	**Fax/Other**	**Online**
Medical and BH	1-866-633-4449	Medical 1-855-705-4542	UHC Provider Portal
BH Only	1-800-658-0569, extension also required		

WELLCARE OF KENTUCKY			
Department	**Phone**	**Fax/Other**	**Online**
Main / Medical PA	1-877-389-9457		Availity*
DME PA	1-800-351-8777		

*Availity.com assistance can be found by calling 1-800-282-4548 (Monday-Friday, 8a.m.- 6p.m.)

For universal assistance with the Prior Authorization (PA) process see the chart below:

Prior Authorization Processes		
Type	**Services**	**Process**
Managed Care Organization (MCO)	Varies by MCO	Review the MAP-9 form Instructions, **complete form MAP-9,** and submit per the direction of the applicable MCO listed on this form
Fee-For-Service (FFS)	Acute Inpatient Services, Dental & Orthodontic, Durable Medical Equipment, EPSDT Special Services, EPSDT Therapy Process, Home Health, Hospice MAP, Nursing Facility Ancillary, Outpatient Services, Physician and Radiology, Private Duty Nursing, and PRTF	Log into your **Essette Provider Portal** at https://kog.chfs.ky.gov Additional Prior Authorization Information/Assistance
Pharmacy (FFS and MCO)	Prescription Medication	MedImpact Electronic Prior Authorization (ePA) Portal