KAISER PERMANENTE®

GEORGIA PRIOR AUTHORIZATION (PRE-CERTIFICATION) REQUEST FORM

Fax the completed form to: **866-452-4585**. Call **404-364-7320** if you have questions.

Please fill in every field; requests **cannot** be processed if they are missing Clinical Information, CPT, or ICD codes. KPGA reserves the right to downgrade urgent requests based on medical necessity.

1. FORM COMPLETED BY:

Name (Print):	Phone:	Fax:	Date:

2. MEMBER INFORMATION:

KP Medical Record Number:	Last Name:	First Name:	
Date of Birth:	Phone:		
Address:	City:	State:	Zip:

3. PRIORITY OF REQUEST:

☐ Routine	Authorization #:
☐ Urgent (Within 72 hours)	☐Renewal of Authorization ☐Modification of Authorization
☐ Post Service (service has been rendered)	Is this a continuity of care request: ☐Yes or ☐No

For Existing Authorizations:

Acute Care:	**Outpatient:**	**Behavioral Health:**
☐ Initial Hospital Admission	☐ Service ☐ Transplant ☐ Transgender	☐ Inpatient ☐ Outpatient
☐ Concurrent Hospital Review	☐ PT/OT/ST ☐ Hospice	☐ Partial Hospital
☐ Observation ☐ Hospice	☐ Drug/Medication ☐ Transportation	☐ Intensive Outpatient ☐ Residential
☐ Transplant ☐ Transgender	☐ Durable Medical Equipment	
Post-Acute:	**Pre-Service:**	**Pre-Service Surgery:**
☐ Home Health Care	☐ In-Office Procedure	☐ ASC
☐ LTACH	☐ Drug/Medication	☐ Outpatient
☐ Acute Inpatient Rehab	☐ Radiology	☐ Inpatient
☐ Skilled Nursing Facility		

4. PROVIDER INFORMATION

Requesting Provider		**Treating Provider**	
Physician:		Physician:	
Specialty:		Facility Name:	
NPI:		TIN:	NPI:
Phone:	Fax:	Specialty	
Address:		Phone:	Fax:
		Address:	

5. SERVICE INFORMATION

Start Date:				End Date:				
Diagnosis ICD Code(s):								
CPT/HCPCS/ J- Code(s):	# of visits/ Dose Qty	CPT/HCPCS/ J- Code(s)	# of visits/ Dose Qty	CPT/HCPCS/ J- Code(s)	# of visits/ Dose Qty	CPT/HCPCS/ J- Code(s)	# of visits/ Dose Qty	
1.		4.		7.		10.		
2.		5.		8.		11.		
3.		6.		9.		12.		

6. COMMENTS
