Kentucky Medicaid
Adult Inpatient Psychiatric Authorization Request Form

Member Information			
Member Last Name:	Member First Name:	Date of Birth:	Age:
Medicaid ID#:	Member Address:	City:	Zip Code:

Provider Information		
Facility Name:	NPI:	Tax ID:
Facility address:	City:	Zip Code:
Facility Contact Person:	Facility Contact Number:	

Admission/Request Details:			
Date of Admission:		Admitting Physician:	
Admission Status: ☐ Voluntary ☐ Involuntary		Date of Request:	
Diagnosis:	ICD 10 Code:	Diagnosis:	ICD 10 Code:
Diagnosis:	ICD 10 Code:	Diagnosis:	ICD 10 Code:
Type of Request: ☐ Admission ☐ Continued Stay	# of days Requested:	Start Date:	End Date:

Form Instructions:

Please complete the sections above for the Medicaid member you are requesting services for. **You must submit clinical documentation to support the medical necessity of this request** to include at a minimum: a Facesheet, History and Physical, Emergency Room Summary, person centered care

plan, discharge plans, and any other clinical documentation including any assessments that will assist with the reviewers assessment of InterQual criteria for approval/denial. If information is missing, or deemed not sufficient you will receive a Lack of Information notice which will request additional documentation. Please note this request does not guarantee services will be authorized.

Notes/Additional Comments: