MAP 650
Rev 3/2021

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
EPSDT Special Services Fax Request form for:
Occupational Therapy, Physical Therapy, and/or Speech Therapy
Carewise Health Phone 800-292-2392

Date: _____

Reference #: _____ New Certification: YES / NO Recertification: YES / NO Change: _____

Provider Name: _____ Provider #: _____

Provider Address: _____

Provider Contact Name: _____ Phone: _____

Patient Name: _____ DOB: _____ Sex: _____

Medicaid #: _____ Parent/Guardian: _____ Phone: _____

Address: _____ County Code: _____

1. Diagnosis: _____ ICD 10: _____ 2. Diagnosis: _____ ICD 10: _____

Ordering Provider Information

Name: _____

Address: _____

Phone: _____ License Number: _____

Service(s) Requested and Location	Procedure Code	# of Units	State Date	End Date	$ Requested

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Please fax completed form to Carewise Health at 1-502-429-5233. If any changes/new MD orders occur before next recertification is due, please contact Carewise Health immediately at 1-800-292-2392. Please submit fax form with initial request and recertifications every 90 days for therapy.

Patient Name: _____ Medicaid ID #: _____

Does the child receive other services? (Check box if yes)

- ☐ First Steps Explain: _____
- ☐ Other EPSDT Explain: _____
- ☐ School Services Explain: _____
- ☐ OCSHCN Explain: _____
- ☐ HCB Waiver Explain: _____
- ☐ Michele P Waiver Explain: _____
- ☐ Other Waiver Explain: _____
- ☐ Home Health Explain: _____
- ☐ PPEC Explain: _____

Equipment used during the therapy session pertaining to the request (example: therapy ball, mini trampoline, etc): _____

Medical Appointments/ER Visits/Hospitalizations within the past 6 months: _____

Brief update/narrative of therapy: _____

Care Coordinator: _____ Date: _____

Therapist Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Clear Form

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Explanation and Instructions

The EPSDT Special Services Fax Form is used by Kentucky Medicaid providers for Physical Therapy, Occupational Therapy and Speech Therapy preauthorizations. Physical Therapy, Occupational Therapy, and Speech Therapy can be authorized as an EPSDT Special Service after the services the member is entitled to in Medicaid have been exhausted.

The form is designed to be a complete and thorough instrument that is:

1. Utilized for the home health agency to certify that the recipient medically needs the service;
2. Utilized to document that the care coordinator and therapists have reviewed the plan of care and updated as needed;
3. Utilized to document that the service location is part of the preauthorization process;
4. Utilized by Carewise Health as an accessory tool to approve or deny EPSDT Special Services.

General Information

- All EPSDT Special Services must be prior authorized.
- It is the provider's responsibility to verify patient eligibility every month before providing the services.
- When services are requested, it is important to "paint a picture" for the reviewer, so that all-relevant information about the case is presented.
- KCHIP Phase III children are not eligible for EPSDT Special Services.
- Preauthorization is done on a case by case basis and is based on the medical necessity for the service.
- If a preauthorization is requested, a letter with the PA number will be issued in 15 days. If you have not received the letter in 15 days, please call Carewise Health and follow-up on the request.
- Always look at your PA letter before billing the claim. Make sure the number of units, dates, codes and money amounts are correct before billing.
- The time frames for authorization for services depend on the actual service. Therapy is typically authorized for 90 days.

Important Phone Numbers:

Carewise Health – 800-292-2392
Kentucky Medicaid Provider Enrollment – 877-838-5085
Kentucky Medicaid Provider Relations – 800-807-1232
Medicaid EPSDT Special Services – 502-564-9444

Completing the Fax Form

1. Date - Enter the date fax form filled out by provider
2. Reference # - Enter the assigned Carewise Health's internal tracking number (this is **not** the same number as the preauthorization number), if known.
3. New Certification – Circle "YES" if this is a new service request. If this is not a new request, circle "NO."
4. Recertification - Circle "YES" if this is a recertification request. If this is not a recertification request, circle "NO."
5. Change - Enter if a change occurs in the current treatment or goals and is documented with a doctor's order.
6. Provider Name - Enter your agency name.
7. Provider # - Enter agency's provider number (ESPDT Special Services Provider numbers are no longer required to provide EPSDT Special Services).
8. Provider address - Enter the street address, city and state of the Provider.
9. Contact name - Enter the name of the person from the agency who called in the review.
10. Phone # - Enter the provider phone number.
11. Patient Name - Enter the first, middle and last name of recipient.
12. DOB - Enter the recipient's date of birth.
13. Sex - Enter the sex of the recipient.
14. Medicaid # - Enter the recipient's Medicaid number - all 10 digits.
15. Parent/Guardian - Enter the name of recipient's parent or guardian.
16. Phone - Enter the patient's phone number.

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17. Address - Enter the patient address.
18. County code - Enter the patient's residence county code.
19. 1. Diagnosis - Enter the patient's primary diagnosis.
20. ICD-10 - Enter the ICD-10 diagnosis code for the primary diagnosis.
21. 2. Diagnosis - Enter the secondary diagnosis.
22. ICD-10 - Enter the ICD-10 diagnosis code
23. Ordering Provider Information:
    1. Name- Enter the recipient's ordering physician
    2. Address- Enter the physician's address
    3. Phone #- Enter the physician's phone number
    4. License #- Enter the physician's license number
24. Service Requested - Enter type of service requested (Occupational Therapy, Physical Therapy, and/or Speech Therapy) AND where service will be rendered (office, home).
25. Procedure Code - Enter the applicable procedure code requested.
26. # of Units - Enter the number of units requested for the services
27. Start date - Enter the first date of service for the certification/recertification period
28. End date - Enter the last date of the certification or recertification period
29. $ Requested - Enter the estimated dollar amount of each EPSDT service (Please check the corresponding Kentucky Medicaid Therapy Fee Schedule if applicable).
30. Patient name - Enter the patient name.
31. Medicaid # - Enter the 10 digit Medicaid number.
32. Does the child receive other services? (check corresponding box if applicable)
    a. First Steps - Explain what services the child receives from First Steps.
    b. Other EPSDT- Explain what services the child receives from EPSDT.
    c. School Services- Explain what services the child receives from school through their IEP.
    d. CCSHCN- Explain what services the child receives from the Commission for Children with Special Health Care Needs.
    e. HCB Waiver- Explain what services the child receives from Home and Community Based Waiver including Personal Care services.
    f. Michele P Waiver - Explain what services the child receives from the Michele P Waiver.
    g. Home Health - Explain what services the child receives from regular home health services.
    h. PPEC – Provider the name of the facility and explain what services the child receives from their Prescribed Pediatric Extended Care Facility.
33. Equipment used in the home - Explain what equipment the therapist will be using in session and in the plan of care.
34. Medical Appointments/ER Visits within the last six months - Explain any visits that may be pertinent to continuing care for the child.
35. Brief update - Explain all the important facts that will help the reviewers decide why the child needs the services and what exactly the provider will be doing for the child.
36. Care Coordinator - Please have the person who is in charge of the case sign this line.
37. Therapist Signature - Please have all the therapists involved for this request to sign this form.