Oregon Medicaid Prior Authorization Request

KF-007

Plan of Care Request for Behavioral Health Residential or Personal Care Services

Send completed requests to KEPRO via one of the following methods:

☐ FAX to: 1-844-673-8034

☐ Send via secure email to: OR1915i@kepro.com

☐ Postal Mail to: 1750 Blankenship Road
Suite 425
West Linn, Oregon 97068

Use this form to request a plan of care for adult foster care or residential personal care/habilitation services.

Include a copy of the following:

☐ Mental/Behavioral Health Assessment signed by QMHP within 1 year of service start date for current authorization.
☐ LSI must be completed by within 1 year of authorization start date by a QMHA or higher.
☐ Residential care plan (if not included in the ISSP) must be within 1 year of authorization start date.
☐ (FOR AFH ONLY) LOCUS signed by QMHA or higher qualification. Within 1 year of authorization start date.
☐ Submission must be within 30 days (before or after) of authorization start date.
☐ Clinical Information that reflects the past 90 days.

***Please provide a fax number that KEPRO can send correspondence to.**

MEMBER INFORMATION

Last Name:	First Name:
Date of Birth:	Medicaid ID (*prime number*):
Social Security Number:	Primary ICD-10 Diagnosis Code:

REQUEST INFORMATION

This request is for (*select one*): ☐ Initial Request	☐ Reauthorization
Behavioral Health Program Name:	Date of Admission (*MM/DD/YYYY*):
Referring Provider MCD Number:	Rendering Provider MCD Number:
Level of Care (*select one*): ☐ AFH ☐ RTH ☐ RTF ☐ SRTF County of Responsibility:	Rate: $ per (*select one*) ☐ month ☐ week ☐ day
Procedure Code:	Modifiers: ☐ HK ☐ HE ☐ TG ☐ HW
Number of Units Requested (*over full duration*):	
Dates of Service: From (*MM/DD/YYYY*):	To (*MM/DD/YYYY*):
LOCUS© Composite Score:	LSI Composite Score: Add-On:

SIGNATURES

By signing below, the Community Mental Health Program (CMHP) and Mental Health Organization (MHO) or Coordinated Care Organization (CCO) verify that they have reviewed the above services and recommend them for this member.

CMHP representative signature	Name and title	Date
MCO/CCO representative signature	Name and title	Date

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