

## Oklahoma Health Care Authority STATE OF OKLAHOMA Oklahoma Health Care Authority Prior Authorization Request **Prior Authorization Request**

Initial Request	Additional Documentation
Amended	Photos/Videos Included

NPI / ZI Physici Phone: Signatu	bing ian No.: P+4 ian Name: ure:		)	Date:	Address	RID: Name: Birth: Guardian:			
SECTI Estima		of Tro	astment:		Diagnos	rie Codo(e):			
						sis Code(s):			
SECTI	ON IV					SECTION V			
Servici	ng Prov.					Date Span of Service	From:		
	o. & Loc.:						To:		
NPI / ZI 				- /	-	Assignment Code (Select from below):			
Phone:				Fax: ()		(01) Home Health	(08) Audiology	(26) Clinic	
Addres	vider Name:					(02) Hospital IP Facility or Hospital IP Physician	(12) DME	(37) Hospice	
City/Sta	ate/Zip:					(03) Hospital OP	(17) Vision Care	e (40) High Risk OB	
Signature of Servicing Prov.: Date:				(04) Physician	(21) PD Nursing				
001 1101	n vicing Prov.: Date:					(06) Transplant	(25) Lab and X-Ray		
SECTI	ON VI - D	o Not	Skip Lines or PA w	ill be Cancelled					
LINE ITEM			MODIFIER	DESCRIPTION (Must Be On One Line		ne)	TOTAL UNITS FOR DATE SPAN	TOTAL BILLED CHARGES	
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