



**Behavioral Health Unit
Prior Authorization Amendment Form**

Fax to (405) 530-7260

****Amendments MUST be received within 30 days of the date of service****

****Please allow up to 5 business days to process your request****

Agency Provider Name & Billing ID: _____

Contact Name & Email: _____

PA Number: _____

Member Name: _____

Member RID: _____

Type of Change (click all that apply)

_____ **Change Servicing Provider – NEW Servicing Provider:** _____

_____ **Member RID Change – Member’s NEW RID:** _____

_____ **Date Change**

_____ **Unit Change**

PAs allow up to 12 line items. Please indicate below how the specific line item you need to change/add SHOULD read. Please note: if a claim has paid off of the specific line item you want to amend, the paid claim will have to be voided prior to the line item being changed.

Line	Authorized From Date	Authorized To Date	Units
Line A			
Line B			
Line C			
Line D			
Line E			
Line F			
Line G			
Line H			
Line I			
Line J			
Line K			
Line L			