

MEDICAID
Traumatic Brain Injury Waiver Services
Prior Authorization Cover Sheet

Agency Name: _____

Agency Address: _____

Provider Number: _____

Contact Person: _____

Telephone Number: (____)____-____

Program

Participant's Name: _____

Medicaid Number: _____

Submission Date ____/____/____

	Total Units per month Previously approved	Total Units Requesting per month	Service Period for this request	Total Number of Units for this period
Case Management T1016UB			FROM: TO:	
Personal Attendant Services Traditional Model S5125UB Personal Options Model S5125 UC			FROM: TO:	
Non-Medical Transportation Traditional Model A0160UB Personal Options Model A0160 U2			FROM: TO:	

Submit to: KEPRO at 1.866.607.9903

Please note:

If form is not correctly completed, it will be returned for completion, please submit the information listed below:

- I. A copy of this cover sheet;
- II. A copy of signed Person-Centered Service Plan;
- III. A copy of the Person-Centered Assessment;
- IV. A copy of the budget;and
- V. Any other information that you feel will help justify your request.

Note: UB codes used for Traditional Service Model and UC/U2 codes used for Personal Option Service Model T1016 UB Case Management used for both Models

