

Traumatic Brain Injury Waiver Services
Prior Authorization Cover Sheet

Agency Name: _____

Agency Address: _____

Agency NPI# _____

Case Manager: _____

Telephone Number: _____ Fax Number: _____

Member's Name: _____

Medicaid Number: _____

Date of Birth _____

ICD-10 Code(s) _____

TBI Waiver Covered Services	Total Units Requesting per month	Service Period for this request	Total Number of Units for Service Period
Personal Attendant Services Traditional Model S5125 UB Personal Options Model S5125 UC		From: To:	
Non-Medical Transportation Traditional Model A0160 UB Personal Options Model A0160 U2		From: To:	
Personal Emergency Response Unit Traditional Model S5161 U5 Personal Options Model S5161 U5 UK		From: To:	
Environmental Accessibility Adaptions-Home Traditional Model S5165 U2 Personal Options Model S5165 U3		From: To:	
Environmental Accessibility Adaptions-Vehicle Traditional Model T2039 U2 Personal Options Model T2039 U3		From: To:	
Pest Eradication Traditional Model S5121 U2 Personal Options Model S5121 U3		From: To:	
Case Management G9002 U2		From: To:	

Submit request through ANG provider portal: <https://portal.kepro.com/>

NOTE: Please attach the information listed below in the Member's UM request Case in ANG.
Incomplete submission will be pended.

I. Prior Authorization Cover sheet

- II. Signed Person-Centered Assessment
- III. Signed Person-Centered Service Plan
- IV. Person-Centered Discovery Tools
- V. Member Controlled Setting Assessment
- VI. COI Exception Form (if applicable)
- VII. A copy of the budget; and
- VIII. Any other information that you feel will help justify your request