COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
KENTUCKY MEDICAID PROGRAM
PRIOR AUTHORIZATION FOR HEALTH-SERVICES (MAP 9) INSTRUCTIONS

Eligibility Information:

1. Please complete the form as described by the instructions listed below.
2. **Check The Member's Medicaid Eligibility -** In order for you to receive payment, the recipient must be eligible for Medicaid on the date of service.
3. Eligibility and benefit information is available to providers via the following:
   - Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
   - Access KyHealth-Net. To request access to or for assistance with KyHealth-Net, please go to: https://chfs.ky.gov/agencies/dms/Pages/kyhealthnet.aspx or contact Gainwell Technologies at KY_EDI_Helpdesk@dxc.com or (800) 205-4696.
   - Contacting the Department for Medicaid Services, Provider Services at (855) 824-5615 or Member Services at (800) 635-2570, Monday through Friday, except Holidays.

Managed Care Information:

Medical benefits for persons whose care is overseen by a Managed Care Organization (MCO) are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ.

Providers with MCO questions should contact the respective MCO provider services. Please see contact list below.

- Aetna Better Health of Kentucky - (855) 300-5528
- Anthem Blue Cross Blue Shield - (855) 690-7784
- Humana Healthy Horizons in Kentucky - (800) 444-9137
- Passport Health Plan by Molina Healthcare - (844) 778-2700
- UnitedHealthcare Community Plan - (866) 293-1796
- WellCare of Kentucky - (877) 389-9457

Saving Information:

The form does not automatically save the entered information if filling out electronically. You must save the form to your computer.

Form Submission:

Once the MAP 9 Authorization Request Form is completed, please **Sign and Date** the form.

- For Private Duty Nursing (PDN) or Durable Medical Equipment (DME) requests, fax the completed, signed MAP 9 and any other documentation to Carewise Health at (800) 807-8843.
  - For DME requests, please submit appropriate MAP 1000 (Certificate of Medical Necessity) along with the completed MAP 9.
  - For questions about the documentation or submission on these forms, please contact Carewise Health at (800) 292-2392 between 8:00am and 6:00pm EST.
- For Dental Services Authorization Requests, please fax the completed, signed MAP 9, x-rays and any other documentation to Gainwell Technologies at (502) 214-3560.
  - For questions regarding submission of Dental, or EPSDT Dental Authorization requests, please contact Gainwell Technologies at (800) 807-1232.

Please Note:

For Early Periodic Screening, Diagnosis and Treatment Special Services (ESPDT SS) Physical Therapy, Speech Therapy and/or Occupational Therapy Authorization requests, please complete the MAP 650 and submit to Carewise Health at (800) 807-8843 or (800) 807-7840. Therapy should not be requested as an EPSDT SS until after the services the member is entitled to in Medicaid have been exhausted.

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Detailed Procedures:

Item #	Description
1.	Enter the Recipient's Ten (10) Digit Medicaid Assistance Identification (I.D.) Number (No).
2.	Enter the Recipient's Last Name.
3.	Enter the Recipient's First Name.
4.	Enter the Recipients Middle Initial (M.I.).
5a.	Enter the Ten (10) Digit Medicaid Provider Number.
5b.	Enter the Ten (10) Digit Medicaid Number of the Prescribing Provider.
6a.	Enter the Provider Name, Address, and Phone Number for the provider number entered in 5a.
6b.	Enter the Prescriber Name, Address, and Phone Number for the provider number entered in 5b.
7.	Select from the drop down box the County # of Recipient Residence.
8.	Enter the Date of Delivery (if already delivered).
9.	Enter the Primary Diagnosis.
10.	Enter the Secondary Diagnosis.
11.	Enter the Date of Birth (MM/DD/YYYY).
12.	Line No. (6 lines available).
13.	Enter the Procedure/Supply Description.
14.	Enter the Procedure Supply Code.
15.	Enter the Units of Service.
16.	Enter the Usual and Customary Charges of the Service Requested.
17.	Leave Blank – For Official Use
18.	Leave Blank – For Official Use
19.	For HCB and Model Waiver Providers, enter Approximate Total Monthly Charge. Leave blank if not applicable.