Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Outpatient Rehabilitation and Therapy

Upload through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

Required documentation which must be uploaded and submitted with this form:

- Plan of Care (POC) must include deficits, chronic or acute, short-term and long-term goals, end goal and progress toward goals
- Doctor's order

Authorization is limited to a 90-day period for recipients age 21 and older and a 180-day period for recipients under age 21. If the doctor's order is for one year, the same order can be attached.

DATE OF REQUEST: _____/_____/_____

REQUEST TYPE: ☐ Prior Authorization ☐ Continued Services ☐ Retrospective Review

REQUIRED FOR RETROSPECTIVE REVIEWS ONLY This recipient was determined eligible for Medicaid benefits on: _____ /_____ /_____
NOTES:

RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID:	DOB:	Phone:
Address *(include city, state, zip)*:		
Guardian Name (if applicable):		Guardian Phone:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	

ORDERING PROVIDER INFORMATION		
Ordering Provider Name:		
NPI:	Phone:	Fax:
Address *(include city, state, zip)*:		
Contact Name:		

SERVICING PROVIDER INFORMATION		
Servicing Provider Name:		
NPI:	Phone:	Fax:
Address *(include city, state, zip)*:		

CLINICAL INFORMATION *Use additional sheet(s) if needed to submit all pertinent medical documentation and justification to be considered in the determination of this request.*

Is this request for Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No
Diagnosis (include ICD-10 codes and descriptions):

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Recipient Name:_____ Date of Request:_____

REQUESTED SERVICES *(enter one code per line)*

CPT Code and Description	Enter Discipline: GP (Physical Therapy), GO (Occupational Therapy) or GN (Speech Therapy)	Units Requested per Week	Number of Weeks
1.			
2.			
3.			
4.			

Functional Deficits and Rehabilitation Diagnoses:

Treatment Goals:

Previous Service or Treatment and Outcome or Results *(include dates of prior services and an explanation of any non-compliance)*:

Other Clinical Information Supporting the Medical Necessity of Requested Services: