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):

Outpatient Rehabilitation and Therapy

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: