Humana Medicaid: Authorization Request Form

Please complete all applicable fields and return via email or fax.
Email: CorporateMedicaidCIT@humana.com **Fax: 833-974-0059**

To expedite your request and avoid delays, please complete this form. Requests also can be made via Availity.com or by calling Kentucky Medicaid at 800-444-9137. When submitting your request, please include medical documentation to be reviewed for medical necessity.

NOTE: An authorization does not guarantee payment by Humana Inc. Responsibility for payment is determined by membership eligibility, benefit limitations and medical necessity.

Date: _____ Time faxed/emailed: _____ □ Urgent/expedited

Enrollee information
Enrollee name: _____ Medicaid ID: _____ Humana ID: _____
Date of birth: _____ Is enrollee pregnant? □ Yes □ No
Enrollee's PCP: _____ Phone: _____
Work-related injury? □ Yes □ No Motor vehicle-related accident? □ Yes □ No
Does enrollee have other insurance? □Yes □No Insurer:_____ Medicare? □Part A □Part B

Information of requesting, treating and/or facility provider □ Enrollee requested
Provider: _____ NPI: _____ Tax ID: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____ Fax: _____
Are any supporting documents included? □Yes □ No Number of documents: _____
Authorization type □ Inpatient □ Outpatient □ BH inpatient □ BH outpatient

Service type

□ Ambulance—air	□ Maternity	□ Electroconvulsive therapy
□ Ambulance—ground	□ Mental health/substance use disorder	□ Applied behavior analysis
□ Consultation only	□ Observation	□ Medication management
□ Consultation with treatment	□ Outpatient surgery/procedure	□ Medication management with therapy
□ Diagnostic testing	□ Therapy services	□ Methadone
□ DME rental	□ Transplant—intensive outpatient	□ Suboxone treatment
□ DME purchase	□ Psychological testing	□ Other: _____
□ Hospice	□ Neuropsychological testing	

□ Clinical trial (If checked, submission of Kentucky Medicaid Attestation Form is required with the prior authorization request. You can find the form online at **Humana.com/KYPriorAuthorizations**)
First day: _____ Last day: _____

Primary ICD-10 code: _____ Description: _____

Procedure/service code	Diagnosis code	Requested service	Unit type

Additional information:
_____

Form completed by: _____ Phone: _____ Fax: _____