AUTHORIZATION ADJUSTMENT REQUEST

Date: _____ UM Manager: _____

Provider: _____ Provider ID: _____

Person Preparing Request (if different from above): _____

The following member(s) requires additional units or additional length of stay for a service currently authorized and the most recently submitted Behavioral Health CareConnection® represents the clinical condition of the member which should be utilized to evaluate this request for additional services.

Member ID	Member Medicaid # (if applicable)	Service Authorized	Authorization #	Start Date	End Date	Units Authorized	Additional Units/LOS Requested	Comments / Other

Please submit this request by Fax: 1.866.473.2354 or email your designated Kepro nurse:

Bethany Frame: bframe@kepro.com Jenny Craft: vcraft@kepro.com Marlene Reed: mreed@kepro.com Brenda Myers: bmyers@kepro.com
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