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 to your designated KEPRO Care Manager either by Fax 1.866.473.2354 or EMAIL

Peggy Madore: pmmadore@kepro.com
Kayla Amos: Kayla.Amos@kepro.com
Joyce Romeo: jromeo@kepro.com
Willa Farley: Willa.Farley@kepro.com
Emily Proctor ebproctor@kepro.com

Thea Johnson: tjohnson@kepro.com
Sarah Shapero: Sarah.Shapero@kepro.com
Melissa Lazear: mlazear@kepro.com
Annie Lane: Annie.Lane@kepro.com
Caroline Duckworth: cgduckworth@kepro.com