



INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Standard/Urgent Requests: **Fax** 833-544-0590

Behavioral Health Requests: **Fax** 833-544-1827

Transplant Requests: **Fax** 833-544-1829

Standard Requests - Determination within 4 calendar days of receipt of request.

Urgent Requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

***Indicates Required Field**

MEMBER INFORMATION

*Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI *Requesting TIN Requesting Provider Contact Name

Requesting Provider Name Phone *Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

*Servicing NPI *Servicing TIN Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

*Primary Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

*Start Date OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)

Additional Diagnosis Code (ICD-10)

***INPATIENT SERVICE TYPE** (Enter the Service type number in the boxes)

- | | |
|------------------------------|----------------------|
| 490 Boarder Baby | 492 Subacute |
| 779 C-Section Delivery | 411 Surgical |
| 121 Long Term Acute Care | 992 Transplant |
| 970 Medical | 720 Vaginal Delivery |
| 300 Neonate | |
| 414 Premature/False Labor | |
| 427 Rehab | |
| 402 Skilled Nursing Facility | |

- Behavioral Health**
- 528 BH Chemical Substance Abuse
- 3.5 3.7 4.0
- 529 BH Psychiatric Admission

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

**Rev. 01 26 2022
IV-PAF-6146**