

INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Standard Request - Determination within 24 hours of receiving all necessary information.

Urgent Request - I certify this request is urgent to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 24 hours.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* 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
779 C-Section
121 Long Term Acute Care
970 Medical
300 Neonate
427 Rehab

402 Skilled Nursing Facility
117 Sub Acute - Nursing Facility
492 Subacute
411 Surgical
992 Transplant
720 Vaginal Delivery

Behavioral Health

535 Residential Treatment - Substance Use
536 Residential Treatment - Mental Health
531 Eating Disorders
529 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.

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