Fax to: 866-724-5057

INPATIENT MEDICAID Prior Authorization Fax Form

☐ Standard Request - Determination within 5 business days of receiving all necessary information.

☐ Expedited Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

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

* *INDICATES REQUIRED FIELD*

MEMBER INFORMATION

Member ID/Medicaid 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)

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

Diagnosis Code * (ICD-10)

Additional Diagnosis Code (ICD-10)

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

Delivery
490 Boarder Baby
720 Vaginal Delivery
779 C-Section

Rehab
427 Rehab

Transplant
922 Transplant

970 Medical
300 Neonate
414 Premature/False Labor
402 Skilled Nursing Facility
492 Sub Acute
411 Surgical

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.