

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.

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)

Start Date OR Admission Date *

(MMDDYYYY)

Diagnosis Code *

(ICD-10)

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)

Delivery

490 Boarder Baby
720 Vaginal Delivery
779 C-Section

Transplant

922 Transplant

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

Rehab

427 Rehab

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: A prior authorization is not a guarantee of payment. Payment may be denied in accordance with Plan's policies and procedures and applicable law.

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