

INPATIENT MEDICAID AUTHORIZATION FORM

Standard requests - Determination made as expeditiously as the member's health condition requires, but no later than 14 calendar days after receipt of request.

Urgent requests - Determination made as expeditiously as the member's health condition requires, but no later than 3 business days after receipt of request.

Concurrent review - Determination made as expeditiously as the member's health condition requires, but no later than 24 hours after receipt of request.

*** Indicates Required Field**

MEMBER INFORMATION

Medicaid/Member ID * _____ Date of Birth * _____
(MMDDYYYY)

Last Name, First _____



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 *	Additional Procedure Code	Start Date OR Admission Date *	Diagnosis Code *
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)
Additional Procedure Code	Additional Procedure Code	Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity	Additional Diagnosis Code
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)

INPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes)

- | | | |
|---|--|--|
| <p>Delivery</p> <ul style="list-style-type: none"> 490 Boarder Baby 300 Neonate 414 Premature/False Labor 970 Medical 411 Surgical 402 Skilled Nursing | <p>Transplant</p> <ul style="list-style-type: none"> 209 Transplant Surgery 419 Transplant Workup | <p>Rehab</p> <ul style="list-style-type: none"> 479 Inpatient Rehab - Hospital 220 Comprehensive Inpatient Rehab Facility |
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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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