



# INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and Fax to: 1-833-249-2342

**Standard requests** - Determination within 5 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 72 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

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



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

#### Delivery

779 C-Section Delivery  
720 Vaginal Delivery

#### Inpatient Rehab

427 Rehab

#### Transplant

477 Transplant Admission

#### Miscellaneous

970 Medical  
414 Premature/False Labor  
904 Nursing Facility (Residential/Custodial Care)  
402 Skilled Nursing Facility  
411 Surgical  
490 Boarder Baby  
300 Neonate  
492 Sub-acute

#### Behavioral Health

528 BH Chemical Substance Abuse  
529 BH Psychiatric Admission  
531 BH Eating Disorders  
532 BH Crisis Stabilization Unit  
535 BH Residential Treatment - Substance Use  
536 BH Residential Treatment - Mental Health

**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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