



INPATIENT AUTHORIZATION

OHIO

Expedited Requests: **Call** 1-833-998-5024
Standard Requests: **Fax** 1-877-861-6722
Concurrent Requests: **Fax** 1-844-893-2203

For Standard (Elective Admission) requests, complete this form and FAX to 1-877-861-6722. Determination made as expeditiously as the enrollee's health condition requires, but no later than **7** calendar days after the receipt of request.

For Expedited requests, please CALL 1-833-998-5024 Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 1-844-893-2203 (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

***Indicates Required Field**

MEMBER INFORMATION

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 *

(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)

779 C-Section Delivery

121 Long Term Acute Care

970 Medical

904 Nursing Facility Residential

414 Premature/False Labor

427 Rehab

402 Skilled Nursing Facility

411 Surgical

992 Transplant

720 Vaginal Delivery

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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