



# INPATIENT MEDICAID PRIOR AUTHORIZATION FAX FORM

Complete and Fax to:  
All SN/Rehab/LTAC requests  
1-866-529-0291  
All elective and /or scheduled admits  
1-866-529-0290

Elective Request

Urgent 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)

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)

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

- 490 Border Baby
- 779 C- Section delivery
- 121 Long Term Acute Care
- 970 Vaginal Delivery
- 300 Neonate
- 904 Nursing Facility
- 414 Premature/False Labor
- 427 Rehab
- 402 Skilled Nursing Facility
- 411 Surgical
- 992 Transplant
- 720 Vaginal Delivery

### Behavioral Health

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

**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.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

