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)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date* (MMDDYYYY)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)

Diagnosis Code* (ICD-10)

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

Delivery
- 779 C-Section
- 720 Vaginal Delivery

Inpatient Rehab
- 479 Inpatient Hospital
- 220 Comprehensive Inpatient Rehab Facility
- 121 Long Term Acute Care
- 970 Medical
- 414 Premature/False Labor
- 402 Skilled Nursing Facility
- 411 Surgical

Transplant
- 209 Surgery
- 419 Work-up

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.