INPATIENT MEDICAID
PRIOR AUTHORIZATION FAX FORM

buckeye health plan

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)*

490 Border Baby
779 C- Section delivery
121 Long Term Acute Care
970 Medical
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 Residentail Treatment - Substance Use
536 BH Residentail 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.