buckeye health plan | MyCareOhio Connecting Medicare + Medicaid

MEDICARE-MEDICAID PLAN (MMP) INPATIENT AUTHORIZATION

Expedited Requests: **Call** 1-866-389-7690
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 10 calendar days after the receipt of request.

☐ **For Expedited requests, please call 1-866-389-7690** Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe 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 *

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)

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

Are services needed for discharge planning? ☐ **YES** ☐ **NO**

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.