



# INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and Fax to:  
Medical 877-212-6105  
Behavioral 833-286-1086

**Standard requests -** Determination within 5 working days of receiving all necessary information, not to exceed 14 calendar days from receipt.

**Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

**\*Physician Signature** \_\_\_\_\_

**\* Indicates Required Field** \_\_\_\_\_

\*Date of Birth

## MEMBER INFORMATION

\*Medicaid/Member ID

Last Name, First

(MMDDYYYY)

## ORDERING PROVIDER INFORMATION

\*Ordering NPI

\*Ordering TIN

Ordering Provider Contact Name

Ordering 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

Additional Procedure Code

\*Start Date OR Admission Date

\*Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

Additional Procedure Code

Additional Procedure Code

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

Additional Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

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

### Medical

- 970 Medical
- 121 Long Term Acute Care
- 427 Inpatient Rehab
- 402 Skilled Nursing Facility
- 492 Subacute
- 992 Surgical
- 992 Transplant

### Behavioral Health - please send all supporting forms and medical records as necessary based on service

- 528 Chemical Substance Abuse - circle appropriate option:  
ASAM: 3.2 3.7 4.0 AND Involuntary Voluntary
- 532 Crisis Stabilization Unit
- 529 Psychiatric Admission - circle appropriate option: Involuntary Voluntary
- 536 Residential Treatment - Mental Health - circle appropriate option:  
Short Term (less than 30 days) Long Term (greater than 30 days)
- 535 Residential Treatment - Substance Use - circle appropriate option:  
ASAM: 3.1 3.3 3.5

**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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