coordinated care

INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to:
Medical 877-212-6105
Behavioral 833-286-1086
Transplant 833-552-0998

☐ **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 necessaaary 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**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First

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 (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) ☐☐☐

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.