



# INPATIENT MEDICAID AUTHORIZATION FAX FORM

Complete and Fax to: (877) 779-5234

- Concurrent** - (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.
- Urgent** - 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.
- Standard** - Only for elective inpatient procedures with 14 days notice.

**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   Start Date OR Admission Date \*  Diagnosis Code \*   
(CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)

Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   
(CPT/HCPCS) (Modifier) (MMDDYYYY)

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

- |                           |   |
|---------------------------|---|
| 479 Acute Rehab           | 121 LTAC (Long Term Acute Care Hospital)          |
| 492 Sub-Acute             | 402 Skilled Nursing Facility                      |
| <b>Delivery</b>           | 904 Nursing Facility (Residential/Custodial Care) |
| 779 C-Section             | <b>Transplant</b>                                 |
| 720 Vaginal Delivery      | 419 Work-up                                       |
| 414 Premature/False Labor | 209 Surgery                                       |
| 970 Inpatient Medical     |   |
| 411 Surgical              |   |

**Observation Stays do not require Authorization.**

**Send all Hospice requests using the PA O/P Fax from and submit to the PA Fax # 855-332-7955**

**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.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.