

INPATIENT Prior Authorization Fax Form

Standard Request - Determination within 15 calendar days of receiving all necessary information.

Expedited 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.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* 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)

Start Date OR Admission Date *

 (MMDDYYYY)

Diagnosis Code *

 (ICD-10)

Additional Procedure Code

 (CPT/HCPCS) (Modifier)

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

 (MMDDYYYY)

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

Delivery

779 C-Section
 720 Vaginal Delivery

414 Premature/False Labor
 402 Skilled Nursing Facility
 411 Surgical

Inpatient Rehab

479 Inpatient Hospital
 220 Comprehensive Inpatient Rehab Facility

Transplant

209 Surgery
 419 Work-up

121 Long Term Acute Care
 970 Medical

**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 benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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