INPATIENT
Prior Authorization Fax Form

Fax to: 855-537-3447

Determination will be made within 24 hours of receiving the request.

***** ***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)

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

Diagnosis Code *
(ICD-10)

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

Delivery
779 C-Section
720 Vaginal Delivery

929 Hospice Inpatient

Inpatient Rehab
479 Inpatient Hospital
220 Comprehensive Inpatient Rehab Facility

121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical

Transplant
209 Surgery
419 Work-up

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.