

# INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

- Concurrent Request** - Determination within 24 hours of receipt of all necessary information, not to exceed 72 hours from receipt.
- Retro Request** - Determination not to exceed 30 days from date of receipt.

**\*Indicates Required Field**



### MEMBER INFORMATION

\*Member ID  Last Name, First  \*Date of Birth   
(MMDDYYYY)

### ORDERING PROVIDER INFORMATION

\*Ordering NPI  \*Ordering TIN  Ordering Provider Contact Name   
 Ordering Provider Name  Phone  \*Fax

### SERVICING PROVIDER / FACILITY INFORMATION

Same as Ordering Provider

\*Servicing NPI  \*Servicing TIN  Servicing Provider Contact Name   
 Servicing Provider/Facility Name  Phone  Fax

### AUTHORIZATION REQUEST

*Primary Procedure Code <input type="text"/> <small>(CPT/HCPCS)</small>	Additional Procedure Code <input type="text"/> <small>(CPT/HCPCS)</small>	*Start Date <b>OR</b> Admission Date <input type="text"/> <small>(MMDDYYYY)</small>	*Diagnosis Code <input type="text"/> <small>(ICD-10)</small>
Additional Procedure Code <input type="text"/> <small>(CPT/HCPCS)</small>	Additional Procedure Code <input type="text"/> <small>(CPT/HCPCS)</small>	Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity <input type="text"/> <small>(MMDDYYYY)</small>	Additional Diagnosis Code <input type="text"/> <small>(ICD-10)</small>

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

779 C-Section Delivery 121 Long Term Acute Care 970 Medical 300 Neonate 414 Premature/False Labor 427 Rehab 402 Skilled Nursing Facility 411 Surgical 992 Transplant 720 Vaginal Delivery 218 Ventilator	<b>BEHAVIORAL HEALTH</b> 528-BH-Chemical Substance Abuse 529-BH-Psychiatric Admission 532-BH-Crisis Stabilization Unit
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**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.**