mhs health wisconsin

INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 866-467-1316

☐ **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

*Date of Birth (MMDDYYYY)

*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 Ordering 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 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

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.

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