



# INPATIENT AUTHORIZATION REQUEST

\* Check one of the following:

**Fax To: 877-431-8860**

IP    Observation    Skilled Nursing    Rehab    Transition of Care

**\*Required Information** – All required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. **Do not use this form for an urgent^ request. Please call (800) 925-3606.**

\* Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\* Member Plan ID: \_\_\_\_\_ \* DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

\* Member Last Name: \_\_\_\_\_ \* Member First Name: \_\_\_\_\_

Member Phone Number: \_(\_\_\_\_)\_\_\_\_\_

Member

\* Provider ID: \_\_\_\_\_ \* Type: \_\_ PCP \_\_ Specialist

\* Provider Last Name: \_\_\_\_\_ \* Provider First Name: \_\_\_\_\_

\* Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

\* Phone Number: \_(\_\_\_\_)\_\_\_\_\_ \* Fax No.: \_(\_\_\_\_)\_\_\_\_\_

\* Specialty: \_\_\_\_\_ \* RP Contact: \_\_\_\_\_

Requesting Provider

Check this box to skip this section and have the Plan assign the Treating Provider

\* Provider ID: \_\_\_\_\_ \* Specialty: \_\_\_\_\_

\* Provider Last Name: \_\_\_\_\_ \* Provider First Name: \_\_\_\_\_

\* Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

\* Phone Number: \_(\_\_\_\_)\_\_\_\_\_ \* Fax No.: \_(\_\_\_\_)\_\_\_\_\_

Treating Provider

\* Type:  Planned Admission    Emergency Notification   Medical Record#: \_\_\_\_\_

Check this box to skip this section and have the Plan assign the Facility

\* Facility ID: \_\_\_\_\_ \* Facility Name: \_\_\_\_\_

\* Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

\* Phone Number: \_(\_\_\_\_)\_\_\_\_\_ \* Fax No.: \_(\_\_\_\_)\_\_\_\_\_

Facility

Planned Date of Service: \* From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ or Requested length of stay: \_\_\_\_ days

\* Primary ICD-9 Code: \_\_\_\_\_ \* Description: \_\_\_\_\_

Primary CPT-4 Code: \_\_\_\_\_ Description: \_\_\_\_\_

Rev Code: \_\_\_\_\_ Description: \_\_\_\_\_

Please include additional procedure codes as may be applicable in the Clinical Summary below.

\* Pertinent Clinical Summary: (attach supporting clinical records, if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Service Requested

*Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). ^Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life threatening) which should be treated within 24 hours.*