

# Inpatient Notification / Authorization Request Form



**Fax to: (877) 431-8860**

<b>CHECK ONE OF THE FOLLOWING:</b>	
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Observation
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Rehab
<input type="checkbox"/> Transition of Care	
<input checked="" type="checkbox"/> <b>(POS) POINT OF SERVICE BENEFIT OPTION ELECTED BY MEMBER. Higher share of cost for member will apply.</b>	
<p><b>Required Information:</b> In order to ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please completes this form in its entirety. Please type or print in black ink and submit this request to the fax number above.</p>	
<b>MEMBER</b>	
Member Plan ID:	Today's Date:
Member Last Name:	Member First Name:
Member Phone Number:	Date of Birth:
<b>REQUESTING PROVIDER</b>	
Provider ID:	Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist
Provider Last Name:	Provider First Name:
Phone Number:	Fax Number:
Specialty:	RP Contact:
<b>TREATING PROVIDER</b>	
<input type="checkbox"/> 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 Number:
<b>FACILITY</b>	
Type: <input type="checkbox"/> Planned Admission <input type="checkbox"/> Emergency Notification	Medical Record Number:
<input type="checkbox"/> 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 Number:
<b>SERVICE REQUESTED</b>	
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 applicable, in the Clinical Summary below.	
Pertinent Clinical Summary: (Attach supporting clinical records, if necessary).	

*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.*