



INPATIENT AUTHORIZATION REQUEST

Fax To: 877-431-8860

* Check one of the following:

- IP Observation Skilled Nursing Rehab Transition of Care

***Required Information** – In order to ensure our members receive quality care, appropriate claims payment and notification of servicing providers, 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) 951-7719.**

* 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.