



INPATIENT

Complete and Fax to: 1-866-597-7603

PRIOR AUTHORIZATION FORM

Standard requests - Determination within 14 calendar days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY



*** Indicates Required Field**

MEMBER INFORMATION

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

REQUESTING PROVIDER INFORMATION

*Requesting NPI *Requesting TIN Requesting Provider Contact Name

Requesting Provider Name Phone *Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ Same as Requesting Provider

*Servicing NPI *Servicing TIN Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

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

*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

Delivery

779 C-Section Delivery
720 Vaginal Delivery

Inpatient Rehab

479 Inpatient Rehab - Hospital
220 Comprehensive Inpatient Rehab Facility

Transplant

209 Transplant Surgery

Miscellaneous

121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
490 Boarder Baby
300 Neonate

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.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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