sunshine health
Medicare Advantage

INPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: **Call** 1-877-935-8022
Standard/Concurrent Requests: **Fax** 1-877-617-0394

For Standard (Elective Admission) requests, complete this form and FAX to 1-877-617-0394. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please CALL 1-877-935-8022. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

☐ **For Concurrent requests, complete this form and FAX to1-877-617-0394** (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

***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 (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 boxes)

970 Inpatient Medical
411 Inpatient Surgery
402 Skilled Nursing Facility
121 Long Term Acute Care

Inpatient Rehab

479 Inpatient Hospital
220 Free Standing Facility

Transplant

209 Surgery

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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