

# INPATIENT MEDICARE AUTHORIZATION FORM

**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 to 1-877-617-0394** (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

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

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan 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.