



INPATIENT MEDICARE AUTHORIZATION FORM

Expedited Requests: **Call** 1-844-786-7711
Standard Requests: **Fax** 1-844-330-7158
Concurrent Requests: **Fax** 1-844-833-8944

For Standard (Elective Admission) requests, complete this form and FAX to 1-844-330-7158. 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 1-844-786-7711. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard time frame 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 1-844-833-8944 (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within **3 days** 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 *	Additional Procedure Code	Start Date OR Admission Date *	Diagnosis Code *
(CPT/HCPCS) (Modifier)	(CPT/HCPCS) (Modifier)	(MMDDYYYY)	(ICD-10)
Additional Procedure Code	Additional Procedure Code	Discharge Date (if applicable) 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)

Inpatient Rehab

- 970 Inpatient Medical
- 411 Inpatient Surgery
- 402 Skilled Nursing Facility
- 121 Long Term Acute Care
- 779 C-Section Delivery
- 414 Premature/False Labor
- 720 Vaginal Delivery
- 479 Inpatient Hospital
- 220 Comprehensive Inpatient Rehab 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.

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