

INPATIENT PRIOR AUTHORIZATION FORM

Standard requests - Determination within 15 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	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)

Delivery

779 C-Section Delivery
720 Vaginal Delivery

Inpatient Rehab

427 Rehab

Transplant

992 Transplant

Miscellaneous

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

Behavioral Health

528 BH Chemical Substance Abuse
529 BH Psychiatric Admission
531 BH Eating Disorders
532 BH Crisis Stabilization Unit
535 BH Residential Treatment - Substance Use
536 BH Residential Treatment - Mental Health

**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 of Illinois policy and procedures.

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