



# Inpatient Medicaid Authorization Request Form

To submit PA electronically access the portal at [countycare.valence.care](http://countycare.valence.care)

Fax completed form to: 1-800-856-9434

Phone number: 1-855-444-1661

**\* = Required Information**

\*Requestor's Contact Name:

\*Requestor's Contact Number:

PATIENT INFORMATION		
*Member Name:	*Date of Birth:	
*Member ID Number:	Member Phone Number:	
*Service is: <input type="checkbox"/> Elective/ Routine <input type="checkbox"/> Expedited/ Urgent <i>Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.</i> <input type="checkbox"/> Extension to Authorization _____ <input type="checkbox"/> Continuity of Care		
SERVICE TYPE		
<input type="checkbox"/> Surgical Procedure	<input type="checkbox"/> Long-Term Acute Care	<input type="checkbox"/> Maternity
<input type="checkbox"/> Elective Admission	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> NICU Stay
<input type="checkbox"/> Observation Stay	<input type="checkbox"/> Acute Rehabilitation	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Observation Changed to Inpatient	<input type="checkbox"/> Custodial Care	<input type="checkbox"/> Transplant
<input type="checkbox"/> Admit through ER	<input type="checkbox"/> Other _____	<input type="checkbox"/> Hospice
PROCEDURE INFORMATION		
*ICD-10 Diagnosis:	Diagnosis Description:	
*CPT Code: _____ Units: _____	CPT Code: _____ Units: _____	CPT Code: _____ Units: _____
CPT Code: _____ Units: _____	CPT Code: _____ Units: _____	CPT Code: _____ Units: _____
* Date(s) of Service:		
PROVIDER INFORMATION		
Ordering Provider	<input type="checkbox"/> Primary Care Physician	
*Name: _____	*NPI: _____	TIN: _____
*Fax: _____	Phone _____	
*Address:		
Servicing Provider	<input type="checkbox"/> Same as Ordering <b>Same as Facility</b>	
*Name: _____	*NPI: _____	*TIN: _____
*Fax: _____	Phone _____	
*Address:		
Facility	<input type="checkbox"/> N/A	
*Name: _____	*NPI: _____	*TIN: _____
*UR Fax: _____	*UR Phone: _____	
*Address:		

**ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED & RETURNED.**  
**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.