Inpatient Medicaid Authorization Request Form

Visit the provider portal to submit initial authorization requests online at https://www.myidentifi.com

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:
- ☐ Elective/ Routine
- ☐ Expedited/ Urgent — *Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.*
- ☐ Extension to Authorization _____
- ☐ Continuity of Care

SERVICE TYPE

- ☐ Surgical Procedure
- ☐ Elective Admission
- ☐ Observation Stay
- ☐ Observation Changed to Inpatient
- ☐ Admit through ER
- ☐ Long-Term Acute Care
- ☐ Skilled Nursing Facility
- ☐ Acute Rehabilitation
- ☐ Custodial Care
- ☐ Other_____
- ☐ Maternity
- ☐ NICU Stay
- ☐ Mental Health
- ☐ Transplant
- ☐ 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 ☐ *Primary Care Physician*

*Name: *NPI: TIN:

*Fax: Phone

*Address:

Servicing Provider ☐ *Same as Ordering* ☐ ***Same as Facility***

*Name: *NPI: *TIN:

*Fax: Phone

*Address:

Facility ☐ *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.

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