



Inpatient Authorization Request Form

**Indicates a required field*

Requirements: Clinical information and supporting documentation should consist of current physician orders, notes, and recent diagnostics. **Notification is required for any date-of-service change.**

Expedited Requests: If the standard time to make a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-888-453-2534**.

 Fax completed form to **1-888-339-6339**.

Requestor Name*:	Fax*:	Phone*:
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Member Information (please print)

ID Number*:	Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*: / /

Requesting Provider (please print)

ID Number:	NPI/Tax ID*:	
Provider Name*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

Facility (please print)

ID Number:	NPI/Tax ID*:	
Facility Name*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

Attending Provider (please print)

ID Number:	NPI/Tax ID*:	
Provider Name*:	Fax*:	Phone:
Address:	City:	State: ZIP Code:

(continued)

Diagnosis Codes*

ICD-10:	ICD-10:	ICD-10:	ICD-10:
<input type="checkbox"/> Observation <input type="checkbox"/> Waitlist	<input type="checkbox"/> Inpatient Admission <input type="checkbox"/> ICF	<input type="checkbox"/> LTACH <input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> SNF/Sub-Acute Rehab <input type="checkbox"/> Inpatient Rehab
Date of Admission*: / /		Is this a Level of Care Change (OBS to INP)?: <input type="checkbox"/> Yes <input type="checkbox"/> No Observation Admit Date: / /	

Procedure Code(s)*

Description

CPT/HCPC Code:	
CPT/HCPC Code:	
CPT/HCPC Code:	
CPT/HCPC Code:	
CPT/HCPC Code:	

Some authorizations may be delegated to CareCentrix, please check the QRG