



# ATTENTION: Use Updated Prior Authorization (PA) Fax Form

We are processing your request, please use the updated forms for future requests.

This will allow:

- FASTER processing
- EASIER to fill out
- SAVABLE - New forms can be filled out electronically and SAVED with information.

To Fax Authorizations:

1. Download the PA Fax forms directly from [www.allwell.homestatehealth.com](http://www.allwell.homestatehealth.com)
2. Open and fill in requested fields
3. Print and FAX

Complete and fax to: 1-800-800-8000

### Prior Authorization Fax Form

This is a standard admission request that may take up to 7 calendar days to process. If this is an expedited request, please contact us at 1-800-800-8000. If this is a Pediatric Request, please fax to 800-800-8000.

\* INDICATES REQUIRED FIELD

**MEMBER INFORMATION**

Member ID/Member ID # \_\_\_\_\_ Date of Birth # \_\_\_\_\_  
 Last Name, First \_\_\_\_\_  
 Member's \_\_\_\_\_

**REQUESTING PROVIDER INFORMATION**

Requesting NP # \_\_\_\_\_ Requesting Title # \_\_\_\_\_ Requesting Provider Contact Name \_\_\_\_\_  
 Requesting Provider Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**SERVICING PROVIDER / FACILITY INFORMATION**

Same as Requesting Provider

Servicing NP # \_\_\_\_\_ Servicing Title # \_\_\_\_\_ Servicing Provider Contact Name \_\_\_\_\_  
 Servicing Provider/Facility Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**AUTHORIZATION REQUEST**

Primary Procedure Code \_\_\_\_\_ Start Date OB Administrative Date # \_\_\_\_\_ Diagnosis Code # \_\_\_\_\_  
 Secondary Procedure Code \_\_\_\_\_  
 Additional Procedure Code \_\_\_\_\_ Discharge Date (if applicable) (Calendar Month/Day/Year) \_\_\_\_\_  
 Discharge Date (if applicable) (Calendar Month/Day/Year) \_\_\_\_\_

**INPATIENT SERVICE TYPE \*** (Enter the service type number in the boxes)

739	CONCRETE	410	Medical
750	regional delivery	906	Regional (City/Prevalence) Extended Care
		407	Behavioral Health Facility
		604	Prevention/Wellness
		408	Sub-Acute
		21	Bariatric
476	Specialty Hospital		
550	Comprehensive Inpatient		
	INPATIENT		
		008	Transplant
		409	Specialty
		415	Other

ALL REQUIRED FIELDS MUST BE FILLED BY THE PROVIDER. FORMS WILL BE REJECTED. CORRECT ALL MISSING OR INCORRECT INFORMATION AND RESUBMIT. LACK OF CORRECT INFORMATION MAY RESULT IN DELAYED DETERMINATION. \*Indicates required information for a particular program. Member may be eligible for the program even if the member is not currently enrolled. Some programs may require a certain level of care and may require a certain level of care. The information provided on this form is used for administrative purposes only. It does not constitute a contract or any other form of agreement. All information provided on this form is subject to verification and audit. If you are having trouble with this form, please contact us at 1-800-800-8000. © 2015 All Well. All rights reserved. XX-PAF-0000

Sample

Prior Authorization requests can be submitted through the Secure Provider Portal for faster confirmation and response.

<https://provider.homestatehealth.com/sso/login>