home state health

INPATIENT MEDICAID
Prior Authorization Fax Form

Complete and Fax to: 1-866-390-2739

☐ Standard Request - Determination within 14 working days of receiving all necessary information

☐ Urgent Request - 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.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID/Medicaid 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 (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)

Diagnosis Code * (ICD-10)

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

Delivery
- 779 C-Section
- 720 Vaginal Delivery

929 Hospice Inpatient

Inpatient Rehab
- 479 Inpatient Hospital
- 220 Comprehensive Inpatient Rehab Facility

121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical

Transplant
- 209 Surgery
- 419 Work-up

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.