



MEDICARE INPATIENT AUTHORIZATION MISSOURI

Expedited Requests: **Call** 855-766-1452
Standard Requests: **Fax** 844-280-2630
Concurrent Requests: **Fax** 844-223-2101
Behavioral Health Requests: **Fax** 833-516-2669

For Standard (Elective Admission) requests, complete this form and FAX to the appropriate department above. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please CALL 855-766-1452. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 844-223-2101 (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 72 hours of receipt of request.



*** Indicates Required Field**

MEMBER INFORMATION

Member ID *
[Dotted box for Member ID]

Last Name, First
[Dotted box for Last Name, First]

Date of Birth *
[Dotted box for Date of Birth]
(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *
[Dotted box for Requesting NPI]

Requesting TIN *
[Dotted box for Requesting TIN]

Requesting Provider Contact Name
[Dotted box for Requesting Provider Contact Name]

Requesting Provider Name
[Dotted box for Requesting Provider Name]

Phone
[Dotted box for Phone]

Fax *
[Dotted box for Fax]

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI *
[Dotted box for Servicing NPI]

Servicing TIN *
[Dotted box for Servicing TIN]

Servicing Provider Contact Name
[Dotted box for Servicing Provider Contact Name]

Servicing Provider/Facility Name
[Dotted box for Servicing Provider/Facility Name]

Phone
[Dotted box for Phone]

Fax
[Dotted box for Fax]

AUTHORIZATION REQUEST

Primary Procedure Code *
[Dotted box for Primary Procedure Code]
(CPT/HCPCS) [Dotted box for Modifier] (Modifier)

Additional Procedure Code
[Dotted box for Additional Procedure Code]
(CPT/HCPCS) [Dotted box for Modifier] (Modifier)

Start Date OR Admission Date *
[Dotted box for Start Date OR Admission Date]
(MMDDYYYY)

Diagnosis Code *
[Dotted box for Diagnosis Code]
(ICD-10)

Additional Procedure Code
[Dotted box for Additional Procedure Code]
(CPT/HCPCS) [Dotted box for Modifier] (Modifier)

Additional Procedure Code
[Dotted box for Additional Procedure Code]
(CPT/HCPCS) [Dotted box for Modifier] (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity
[Dotted box for Discharge Date]
(MMDDYYYY)

Additional Diagnosis Code
[Dotted box for Additional Diagnosis Code]
(ICD-10)

INPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes) [Dotted box for Service Type Number]

- 779 C-Section Delivery
- 121 Long Term Acute Care
- 970 Medical
- 414 Premature/False Labor
- 427 Rehab
- 402 Skilled Nursing Facility
- 492 Subacute
- 411 Surgical
- 992 Transplant
- 720 Vaginal Delivery

- Behavioral Health**
- 528 BH Chemical Substance Abuse
 - 529 BH Psychiatric Admission

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.

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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