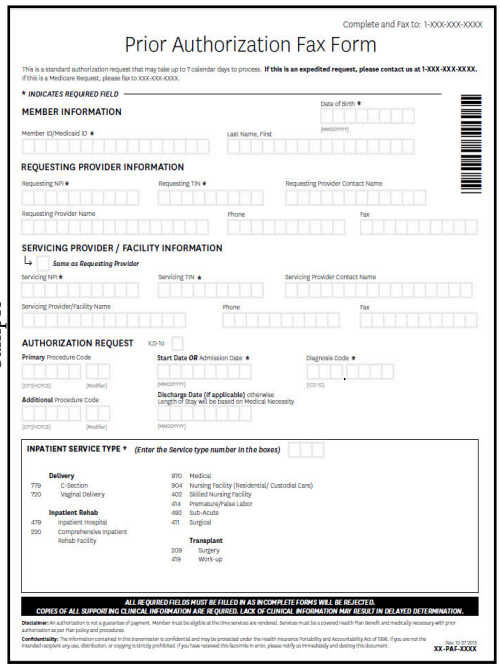
allwell. FROM | home state health.

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.



Complete and Fax to: 1-XXX-XXX-XXXX

Prior Authorization Fax Form

This is a standard authorization request that may take up to 7 calendar days to process. **If this is an expedited request, please contact us at 1-XXX-XXX-XXXX.** If this is a Medicare Request, please fax to XXX-XXX-XXXX.

** INDICATES REQUIRED FIELD*

MEMBER INFORMATION

Member ID/Medicaid ID * | Last Name, First | Date of Birth * (MM/DD/YYYY)

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 ICD-10

Primary Procedure Code (CPT/HCPCS) (Modifier)

Start Date OR Admission Date * (MM/DD/YYYY)

Diagnosis Code * (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MM/DD/YYYY)

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

Delivery
779 C-Section
790 Vaginal Delivery

Inpatient Rehab
479 Inpatient Hospital
290 Comprehensive inpatient Rehab Facility

910 Medical
904 Nursing Facility (Residential/ Custodial Care)
402 Skilled Nursing Facility
414 Premature/False Labor
492 Sub-Acute
411 Surgical

Transplant
309 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.

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 12.17.2015
XX-PAF-XXXX

Sample

To Fax Authorizations:

1. Download the PA Fax forms directly from www.allwell.homestatehealth.com
2. Open and fill in requested fields
3. Print and FAX

Prior Authorization requests can be submitted through the Secure Provider web site for faster confirmation and response.
www.allwell.homestatehealth.com

16090 Swingley Ridge Road, Suite 400 | Chesterfield, MO 63017 | 1-855-766-1452