

INPATIENT AUTHORIZATION REQUEST

Fax To: (888) 890-8219

Check One of the Following

- | | | | |
|---|--|--|--------------------------------|
| <input type="checkbox"/> Inpatient Acute Hospital | <input type="checkbox"/> Observation | <input type="checkbox"/> Skilled Nursing (SNF) | <input type="checkbox"/> Rehab |
| <input type="checkbox"/> Sub Acute | <input type="checkbox"/> Intermediate Care (ICF) | <input type="checkbox"/> Level of Care Change | |

***Required Information** – In order to ensure our members receive quality care, appropriate claims payment and notification of servicing providers, all required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. For an urgent* request, do not fill-out this form. Please call **Medicare** at (888)-505-1201 or **Medicaid** at (888) 846-4262.

Member

Member Plan ID:	Today's Date:	Member COB: <input type="checkbox"/> Yes <input type="checkbox"/> No
Member Last Name:	Member First Name:	
Member Phone Number:	Date of Birth:	

Requesting Provider

Provider ID:	Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist
Provider Last Name:	Provider First Name:
Phone Number:	Fax Number:
Specialty:	RP Contact:

Treating Provider

Check this box to skip this section and have the Plan assign the Treating Provider

Provider ID:	Specialty:
Provider Last Name:	Provider First Name:
Address:	City/State/Zip Code:
Phone Number:	Fax Number:

Facility

Check this box to skip this section and have the Plan assign the Facility

Type: <input type="checkbox"/> Planned Admission <input type="checkbox"/> Emergency Notification	Medical Record Number:
Facility ID:	Facility Name:
Address:	City, State, Zip Code:
Phone Number:	Fax Number:

Service Requested

Planned Date of Service	From:	To:	Requested Length of Stay:	Days
Primary ICD-9 Code:	Description			
Primary CPT-4 Code:	Description:			
Rev Code:	Description:			

INSTRUCTIONS: Please include a clinical summary below including additional procedure codes as applicable. Attach supporting clinical records, if necessary.

Approved 1147 validity date span	From:	To:
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