western sky community care

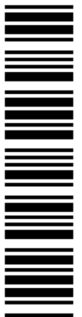
Complete and **Fax** to: 844-805-4593

INPATIENT MEDICAID PRIOR AUTHORIZATION FORM

Standard requests - Determination within 14 calendar days of receiving all necessary information.

Urgent requests - Expedited 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.

*** Indicates Required Field**



MEMBER INFORMATION

*Medicaid/Member 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)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

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

Additional Diagnosis Code (ICD-10)

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

490 Boarder Baby
779 C-Section Delivery
479 Inpatient Rehab
970 Medical
300 Neonate
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
209 Transplant Surgery
720 Vaginal Delivery

Long Term Acute Care

119 Inpatient Hospital
122 Skilled Nursing Facility
285 Nursing Home

BEHAVIORAL HEALTH

528 BH Chemical Substance Abuse
529 BH Psychiatric Admission
526 BH RTC-CD
527 BH RTC-MH

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. 10 04 20178
NM-PAF-5845