



July 6, 2026

Nevada Medicaid Web Announcement 3958

Attention All Providers: Reminder of Retrospective Authorization Requirements

Nevada Medicaid would like to remind providers that when a member is determined to be eligible during their inpatient stay, retrospective authorization must be requested within 10 business days of the date of the eligibility decision. If a member is determined to be eligible for Medicaid benefits after service is provided (or after discharge), a retrospective authorization may be requested within 90 calendar days from the date of decision (DOD).

Retrospective authorization requests require the following documentation:

- Give a synopsis of the medical necessity of all dates of service being requested.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
Note: Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.
- Discharge (DC) Summary (only if the member has been discharged).

Additionally, providers are reminded that if a member changes eligibility from a Managed Care Organization (MCO) to Fee-for-Service (FFS), but the MCO has authorized the specific service and dates, that authorization documentation from the MCO should be included in the authorization request to Nevada Medicaid. Authorization requests must be submitted within 30 calendar days of receipt of the Explanation of Benefits or notification from the MCO regarding the change.

Please refer to the [Billing Manual Chapter 4](#) for information related to prior and retrospective authorization.