

Inpatient Medical and Surgical

Fax this request to: (866) 480-9903

For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: ____/____/____

REQUEST TYPE: Admission Concurrent Review Retrospective Review*
 Reconsideration Unscheduled Revision

*Date of Medicaid Eligibility Decision (for Retrospective Reviews only): ____/____/____

Current prior authorization (PA) number, if applicable: _____

RECIPIENT INFORMATION			
Recipient Name (Last, First, MI):			
Recipient ID:		DOB:	
Address:		Phone:	
City:	State:	Zip Code:	
Guardian Name (if applicable):		Guardian Phone:	
Medicare Insurance Information: <input type="checkbox"/> Part A <input type="checkbox"/> Part B Medicare ID#:			
Other Insurance Name:		Other Insurance ID#:	
ORDERING PROVIDER INFORMATION			
Ordering Provider Name:		NPI:	
Address:		Contact Name:	
City:	State:	Zip Code:	
Phone:		Fax:	
SERVICING PROVIDER INFORMATION			
Facility Name:		NPI:	
Facility Address:		Contact Name:	
City:	State:	Zip Code:	
Phone:		Fax:	
CLINICAL INFORMATION			
Is this request for Healthy Kids (EPSDT) referral/services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Service Type: <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Maternity <input type="checkbox"/> Pediatric <input type="checkbox"/> Observation			
Estimated Admission Date:		Dates Requested: From: To: Number of days:	
Admission Diagnosis		Description	
1.			
2.			
3.			
Other Diagnosis		Description	
1.			
2.			
3.			
Requested Procedures		Description	
1.			
2.			
3.			

