california health & wellness

INPATIENT MEDICAID
Prior Authorization Fax Form

Fax to: 866-724-5057

☐ Standard Request - Determination within 5 **business** days of receiving all necessary information.

☐ 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.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* ***INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Member ID/Medicaid 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)

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

Diagnosis Code * (ICD-10)

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

Delivery
- 779 C-Section
- 720 Vaginal Delivery

929 Hospice Inpatient

Inpatient Rehab
- 479 Inpatient Hospital
- 220 Comprehensive Inpatient Rehab Facility

970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical

Transplant
- 209 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: A prior authorization is not a guarantee of payment. Payment may be denied in accordance with Plan's policies and procedures and applicable law.

Rev. 12 17 2015
CA-PAF-0700