CountyCare HEALTH PLAN

INPATIENT MEDICAID
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-866-209-3703

☐ Concurrent: (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits) - Determination within 24 hours of receipt of all necessary information.

☐ Urgent 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

ICD-9 ☐ ICD-10 ☐

Primary Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-9/ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

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

INPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes) ☐☐☐

479 Acute Rehab

Delivery
779 C-Section
720 Vaginal Delivery

929 Hospice Inpatient
970 Inpatient Medical
121 LTAC (Long Term Acute Care Hospital)

904 Nursing Facility (Residential/Custodial Care)
414 Premature/False Labor
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical

Transplant
209 Surgery
419 Work-up

Observation Stays do not require Authorization.

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.