

## Request for Prior Authorization – Inpatient Services

(Medicaid services only)

In order to efficiently process your request, the information below must be completed.

<b>Member Information:</b> Full Name: _____ Address: _____ Telephone #: (____) _____ DOB: ____/____/____ Medicaid #: _____ Primary Insurance Name (COB): _____ Primary Insurance ID and Effective Date: _____	
<b>Request Type:</b> <input type="checkbox"/> Concurrent <input type="checkbox"/> Retrospective	
<b>Inpatient Services</b> <input type="checkbox"/> Hospitalization - notification of admission Admit Time: _____ <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> LTAC <input type="checkbox"/> Hospice	<input type="checkbox"/> Inpatient rehabilitation <input type="checkbox"/> IMD Other: _____
Diagnosis Code and Description: _____ CPT/HCPCS Code and Description: _____ Number of Days Requested: _____ DOS From: ____/____/____ To: ____/____/____	
<b>Please send clinical notes and all supporting documentation</b>	
<b>Requesting Provider:</b> Name: _____ NPI #: _____ TIN#: _____ AHCCCS ID: _____ Address: _____ Telephone #: _____ Fax #: _____ Contact Name/Phone #: _____	<b>Servicing Provider:</b> Name: _____ NPI #: _____ TIN#: _____ AHCCCS ID: _____ Address: _____ Telephone #: _____ Fax #: _____ Contact Name/Phone #: _____

Submitted By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_  
 (Please Print)

**Please submit all supporting documentation and any applicable information with this request form**

Utilization management department phone number: (800) 424-5891

Inpatient utilization management department fax number: (888) 656-2201

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