IMPORTANT INSTRUCTIONS FOR COMPLETING THIS FORM

Please read these instructions carefully before completing this form. Thank you!

- For each authorization request, please print a **new form** directly from our website. **Do not make copies of the form for future use**.
- **Type** your responses whenever possible. Handwriting is difficult for our automated ocular recognition software system to read; however, if you need to handwrite, please **print and use black ink**.
- Fax your authorization requests **as early in the day** as possible. Documents sent **after 5 p.m.** will not be processed until the **following business day**.
- To improve processing time, fax prior authorization requests and medical records **one member** at a time.
- Mark prior authorization requests as **Urgent** or **Standard** in the appropriate form field. If you handwrite "urgent" on the form or in the notes on a coverage page, it may be missed.
- If you do not receive a determination within the requested time frame, please call us before resending documents. If you do not call, a duplicate request could be processed, which slows intake.
- Make sure to submit this form to the **appropriate fax number**.

univera HEALTHCARE an excellus company

INPATIENT PRIOR AUTHORIZATION FORM

For Physical Health Fax to: 1-844-279-7140
For Behavioral Health Fax to: 1-844-878-6989
For Medical Specialty Drug Fax to : 1-855-346-4418

☐ **Standard requests**

☐ **Urgent requests-** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) to avoid complications and unnecessary suffering or severe pain

After hours, weekends, and holidays requests will be processed the next business day as received.

***Indicates Required Field**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First

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)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

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

Additional Diagnosis Code (ICD-10)

*INPATIENT SERVICE TYPE

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

121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical
904 Nursing Facility Residential

Delivery
779 C -Section (if > 4 days)
720 Vaginal Delivery (if > 2 days)

Inpatient Rehab
479 Inpatient Hospital
220 Comprehensive Inpatient Rehab Facility

Transplant
209 Surgery
419 Work-up

Behavioral Health
255 Partial Hospitalization Program
320 Psychiatric Inpatient
451 OASIS Residential Treatment Per Diem
452 Medically Supervised Inpatient SUB Withdrawal Detoxification
453 Medically Managed Withdrawal
454 Inpatient SUD Rehab
456 Inpatient Hospital SUD Detox

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.

Rev. 08 23 2017
NY-PAF-1085