Iowa Medicaid
IOWA HHS

# INPATIENT MEDICAID
## PRIOR AUTHORIZATION FORM

☐ **Standard Request** - Determination within **14** calendar days of receiving all necessary information.

☐ **Urgent Request** - Expedited request necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function. Authorization decision will be done within **72** hours of receipt of request. **42 CFR §438.210**

***If Concurrent Request, write Authorization #**

☐ **Iowa Total Care** ☐ **Wellpoint** ☐ **Molina Healthcare** ☐ **Fee for Service**

*** Indicates Required Field**

### MEMBER INFORMATION

*Medicaid/Member ID

*Date of Birth (MMDDYYYY)

Last Name, First

### REQUESTING PROVIDER INFORMATION *Address Required on Supplemental Form*

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

### SERVICING PROVIDER / FACILITY INFORMATION *Address Required on Supplemental Form*

↳ ☐ 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)

***Start Date *OR*** Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

**End Date *OR*** Discharge Date (MMDDYYYY)

Total Units/Visits/Days For Primary CPT Code

☐ Additional codes will be provided on Supplemental Information Form

☐ ***Please mark if including clinical information with the request***

**(Enter the Service type number in the boxes)** (Iowa Total Care)

***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.

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