allwell. FROM sunflower health plan.

# INPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: **Call** 1-855-565-9519
Standard/Concurrent Requests: **Fax** 1-844-885-3724

**For Standard (Elective Admission) requests, complete this form and FAX to 1-844-885-3724.** Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

**For Expedited requests, please CALL 1-855-565-9519.** Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

☐ **For Concurrent requests, complete this form and FAX to 1-844-885-3724.** (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.

***Indicates Required Field**

## MEMBER INFORMATION

Member 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)

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) ☐☐☐

779 C-Section Delivery
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
427 Rehab
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical
209 Transplant
720 Vaginal Delivery

**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.**



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