INPATIENT MEDICAID
PRIOR AUTHORIZATION FAX FORM

KanCare **sunflower health plan.**

☐ Standard Request - Determination within 24 hours of receiving all necessary information.

☐ Urgent Request - I certify this request is urgent 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, within 24 hours.

X _____

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Date of Birth *
(MMDDYYYY)

Member ID/Medicaid 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)

Start Date *OR* Admission Date *
(MMDDYYYY)

Diagnosis Code *
(ICD-10)

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)*

490	Boarder Baby	
779	C-Section Delivery	
479	Inpatient Rehab - Hospital	
121	Long Term Acute Care	
970	Medical	
300	Neonate	
414	Premature/False Labor	
402	Skilled Nursing Facility	

492	Sub-Acute
411	Surgical
209	Transplant Surgery
720	Vaginal Delivery

BEHAVIORAL HEALTH

512	BH community Based Services
528	BH Chemical Substance Abuse
531	BH Eating Disorders
529	BH Psychiatric Admission
526	BH RTC-CD
527	BH RTC-MH

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.