louisiana healthcare connections

Complete and Fax to: 1-877-401-8175

INPATIENT
PRIOR AUTHORIZATION FAX FORM

☐ Standard Request - Determination within 14 calendar days of receipt of request--Used for Scheduled Admissions.

☐ Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

☐ Acute, non-scheduled admission - Determination within 24 hours from receipt of request. Chronic Needs Case: ☐ Yes ☐ No

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

***** ***INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Member ID/Medicaid 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)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-10)

ESPD Coordinator Name

ESPD Coordinator Phone

Additional Procedure Code (CPT/HCPCS) (Modifier)

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

ESPD Coordinator Fax

INPATIENT SERVICE TYPE * ***(Enter the Service type number in the boxes)*** ☐☐☐

Delivery
- 779 C-Section
- 720 Vaginal Delivery

Inpatient Rehab
- 479 Inpatient Hospital
- 220 Comprehensive Inpatient Rehab Facility

- 970 Medical
- 414 Premature/False Labor
- 411 Surgical

Transplant
- 209 Surgery
- 419 Work-up

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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