TRILLIUM INPATIENT AUTHORIZATION

Trillium Community Health Plan

Expedited Medicare Requests Call: 1-844-867-1156
Fax Other Requests to:
(844) 371-7765 Medicare
(866)-703-0958 Medicaid

☐ **Standard (Elective Admission Requests)** - Determination made as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days after receipt of request

☐ **Urgent Medicaid 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.

☐ **Concurrent Request**s (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)

Start Date *OR* Admission Date* (MMDDYYYY)

Primary 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)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Diagnosis Code (ICD-10)

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

779 C-Section	121 Long Term Acute Care
970 Medical	402 Skilled Nursing Facility
300 Neonate	492 Sub Acute
414 Premature/False Labor	411 Surgical
479 Inpatient Rehab - Hospital	992 Transplant
220 Comprehensive Inpatient Rehab Facility	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.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter 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.