Community Health Plan

AUTHORIZATION

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 14 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 Requests (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

INDICATES REQUI	RED FIELD	Date of Birth							
MEMBER INFOR	MATION								
Member ID		Leat Name - First	(MMDDYYYY)						
			Last Name, First						
REQUESTING PF	ROVIDER IN	FORMATION							
Requesting NPI *		Requesting TIN * Re		Requesting P	equesting Provider Contact Name				
Requesting Provider Name*		and hanadaanahaanahaanahaanaha	Phone *	haanadhaanadhaanad		Fax			
300003		CILITY INFORMATION							
········ *	questing Provide								
Servicing NPI		Servicing TIN	Servicing TIN Servicir			Provider Contact Name			
	+								
Servicing Provider/Facility Name*		Phone*				Fax			
AUTHORIZATIO	N REOUES	т							
Primary Procedure Coo			Start Date OR Admission Date * Primary Diagnosis Code						
		Start Date On	Admission Date		Filliary Dia				
					(100.00)	<u>.</u>			
(CPT/HCPCS)	(Modifier)	(MMDDYYYY) Discharge Dat	e (if annlicable) of	herwise	(ICD-10)				
Additional Procedure (Code	Length of Stay	Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity			Additional Diagnosis Code			
(CPT/HCPCS)	(Modifier)	(MMDDYYYY)				(ICD-10)	····· - ···		
Additional Procedure Code									
		(Enter the service ty	(Enter the Service type number in the boxes)			Additional Diagnosis Code			
(CPT/HCPCS)	(Modifier)	779 C-Section		Ferm Acute Care		(ICD 10)			
		970 Medical 300 Neonate	492 Sub A			(ICD-10)			
Additional Procedure	Code	414 Premature/False Labor				Additional	Diagnosis C	ode	
		479 Inpatient Rehab - Hospital992 Transplant220 Comprehensive Inpatient Rehab720 Vaginal Delivery							
(CPT/HCPCS)	(Modifier)	Facility				(ICD-10)			
						(100-10)			

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.

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