TRILLIUM INPATIENT 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 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
970 Medical
300 Neonate
414 Premature/False Labor
479 Inpatient Rehab - Hospital
220 Comprehensive Inpatient Rehab Facility
121 Long Term Acute Care
402 Skilled Nursing Facility
492 Sub Acute
411 Surgical
209 Transplant Surgery
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.