



**Illinois Medicaid
Inpatient Services Prior Authorization Form**
Fax (877) 431-8860

SELECT THE APPROPRIATE REQUEST TYPE											
<input type="checkbox"/> Inpatient		<input type="checkbox"/> Observation		<input type="checkbox"/> Skilled Nursing Facility			<input type="checkbox"/> Rehab		<input type="checkbox"/> LTACH		
<input type="checkbox"/> Standard Request		Allow five business days for review of prior authorization requests with receipt of clinical information. If a response has not been received after five business days, call (800) 504-2766 to confirm your request has been received.									
<input type="checkbox"/> Priority Request		Please process ASAP as these services are scheduled on the following date:				Date					
<input type="checkbox"/> Expedited Request		By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.									
<i>By signing below, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.</i>											
Physician Signature Validating Expedited Request							Date Signed				
MEMBER INFORMATION											
Last Name		First Name			Date of Birth						
Harmony ID Number		Phone Number			Other Insurance						
REQUESTING PROVIDER INFORMATION											
Provider Last Name		Provider First Name			Provider ID						
Provider Type		<input type="checkbox"/> PCP <input type="checkbox"/> Specialist		Specialty		Participating		<input type="checkbox"/> Yes <input type="checkbox"/> No*			
Phone Number		Fax Number			Office Contact						
Street Address				City, State		Zip Code					
TREATING PROVIDER INFORMATION											
Provider Last Name		Provider First Name			Provider ID						
Phone Number		Fax Number		Participating		<input type="checkbox"/> Yes <input type="checkbox"/> No*					
Street Address				City, State		Zip Code					
FACILITY INFORMATION											
Type		<input type="checkbox"/> Planned Admission <input type="checkbox"/> Emergency Notification		Facility Name							
Facility ID		Phone Number			Fax Number						
Street Address		City, State			Zip Code						
REQUESTED SERVICE(S)											
Date(s) of Service		From _____ to _____			OR Requested Length of Stay		Days				
Procedure		CPT Code(s)									
Diagnosis		ICD-9 Code(s)									
Please attach documentation to support medical necessity. This includes H&P, progress notes, lab results and treatment plans.											
Clinical Summary											
*If this request is for out-of-network services, please provide an explanation:											

Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergency care does not require prior authorization. An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result (without immediate medical attention) in serious jeopardy to the health of an individual. *Urgent care is defined as medically necessary treatment for an injury, illness or type of condition (usually not life threatening) which should be treated within 24 hours.