

Inpatient Authorization Request Form

Guidelines

For information on medical (Part A and B) prior authorization requirements, visit [UM-22 Prior Authorization Code List](#).

PREAUTHORIZATION REQUESTS (PRESERVICE)

- Preservice should be submitted at least two weeks prior to the date of service or facility admission.
- **If the servicing provider is not part of the Mass Advantage network, please submit this form with a letter of medical necessity (including clinical documentation) explaining why the service(s) can only be provided by an out-of-network specialist.**

CONCURRENT REQUESTS

- Not required prior to emergency care, but authorization for inpatient hospital admission should be submitted within 24 hours of admission to the hospital.

RETROSPECTIVE AUTHORIZATION REQUESTS (POSTSERVICE)

- It is very important that prior authorization procedures are followed for services that require prior authorization. If the referring network provider fails to follow prior authorization protocols, Mass Advantage may decline to pay the claim in which case participating providers will be held financially responsible for services received by the member.
- For more information, visit [Authorization and Notification Procedures](#).
- **Participating providers** seeking retrospective authorization for a Mass Advantage member must file a claim for that service, wait for the claim denial, and then submit a [Provider Request for Claim Review Form \(Contracted\)](#).
- **Non-participating providers** seeking retrospective authorization for a Mass Advantage member must file a claim for service that service, wait for the claim denial, and then initiate the claim appeal process on behalf of the member. Submit a [Provider Request for Claim Review Form \(Non-Contracted\)](#), the appeal process cannot begin with a signed Waiver of Liability Form included in the linked Provider Request for Claim Review Form (Non-Contracted).

FORM SUBMISSION INSTRUCTIONS

- **All fields are required.** Incomplete forms cannot be processed. Please include supporting clinical documentation.
 - Authorization requests and approvals are not a guarantee of payment.
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Inpatient Authorization Request Form



Fax your completed request to (888) 656-7783 or call (866) 312-8467.

1 Priority Level

Admission Date

/ /

- Pre-Service Standard Request Concurrent (Notice of Emergent Admission)
 Pre-Service Expedited Request*

*You can ask for an expedited request if you or your doctor believe your health could be seriously harmed by waiting up to 14 days for a decision. You cannot request an expedited review if you are asking us to pay you back for a medical service/item you've already received.

If Prior Authorization is not required for the requested service, do you require an organizational determination? Yes No

2 Member Information

First Name

Last Name

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Member ID

Date of Birth

	/ /
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3 Requestor Contact Information

Name

Phone Number/Ext.

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Fax Number

Alternate Contact

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4 Physician

Name

NPI

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Address

TIN

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Phone

Fax

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Specialty

- In-Network Out-of-Network
 In-Network Payment Rate

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5 Facility/Agency/Place of Service/Ambulatory Surgery Center

Name	NPI
Address	TIN
Phone	Fax
Type	<input type="checkbox"/> In-Network <input type="checkbox"/> Out-of-Network <input type="checkbox"/> In-Network Payment Rate

6 Requested Services

- | | |
|---|--|
| <input type="checkbox"/> Inpatient Medical Admission | <input type="checkbox"/> Inpatient Rehabilitation Facility |
| <input type="checkbox"/> Inpatient Surgical Admission | <input type="checkbox"/> Inpatient Psychiatric Admission |
| <input type="checkbox"/> Observation Hospital Admission | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Long Term Care Acute Hospital | <input type="checkbox"/> Swing Bed |
| | <input type="checkbox"/> Other: _____ |

ICD10 Codes	CPT/HCPC Codes
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If you have a Reconsideration (Appeal) request, please contact us at (866) 312-8467.