

## INPATIENT AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:

<https://secure.healthx.com/NHCAdvantage.Provider>

Call 1-844-854-6886 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐ Routine/Standard

☐ Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION			
Member Name:		Member ID:	
Date of Birth:		Member Residence:	
REQUESTING PROVIDER/FACILITY			
Requestor's Name (Print):	Phone Number:	Fax Number:	Date of Request:
Referring Provider (If other than requestor):		Referring Provider:	
		<input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other	
SERVICING PROVIDER/FACILITY			
Admitting/ Servicing Facility Name:			
NPI/ TIN Number:		Phone Number:	Fax number:
SERVICE TYPE REQUESTED			
<input type="checkbox"/> Initial Request		<input type="checkbox"/> Extension Request, Previous Auth #:	
Inpatient Services: (Select one)			
<input type="checkbox"/> Observation (OBS) <input type="checkbox"/> Unplanned (via ER) Inpatient Hospital (IP) <input type="checkbox"/> Elective/ Scheduled Inpatient Hospital (IP) <input type="checkbox"/> Inpatient Psychiatric Care <input type="checkbox"/> Other Inpatient:	<input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Inpatient Rehabilitation Facility (IRF)		<input type="checkbox"/> Post-Acute Skilled Nursing Facility (SNF) <input type="checkbox"/> Skill-In-Place (SIP) <input type="checkbox"/> Other post-acute care:
Days/ Visits Requested:		Admission Date/ Date of Service:	
CPT Code (or Description of service being requested):			
Current Primary Diagnoses and ICD-10 Code(s):			

**CLINICAL INFORMATION**

- Clinical/ therapy documentation/ assessments should be within 72 hours of request.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.

**OUT-OF NETWORK SERVICES ONLY**

- Has the service been scheduled already? ☐Yes ☐No
- Is this a specialized service that no other In-network provider can render? ☐Yes ☐No
- Does the member have an established relationship with the provider that should not be interrupted? ☐Yes ☐No

If "Yes", explain (include last visit date):