

MEDICARE-MEDICAID PLAN(MMP)
INPATIENT AUTHORIZATION
MICHIGAN

Expedited Requests: Call 855-323-4578
Standard Requests: Fax 844-930-4389
Concurrent Requests: Fax 844-930-4390

For Standard (Elective Admission) requests, complete this form and FAX to 844-930-4389. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please call 855-323-4578. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 844-930-4390 (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 * [Form field]

Last Name, First [Form field] Date of Birth * [Form field] (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI * [Form field] Requesting TIN * [Form field] Requesting Provider Contact Name [Form field]
Requesting Provider Name [Form field] Phone [Form field] Fax * [Form field]

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI * [Form field] Servicing TIN * [Form field] Servicing Provider Contact Name [Form field]
Servicing Provider/Facility Name [Form field] Phone [Form field] Fax [Form field]

AUTHORIZATION REQUEST

Primary Procedure Code * [Form field] (CPT/HCPCS) [Form field] (Modifier) [Form field]
Additional Procedure Code [Form field] (CPT/HCPCS) [Form field] (Modifier) [Form field]
Start Date OR Admission Date * [Form field] (MMDDYYYY)
Diagnosis Code * [Form field] (ICD-10)
Additional Procedure Code [Form field] (CPT/HCPCS) [Form field] (Modifier) [Form field]
Additional Procedure Code [Form field] (CPT/HCPCS) [Form field] (Modifier) [Form field]
Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity [Form field] (MMDDYYYY)
Additional Diagnosis Code [Form field] (ICD-10)

INPATIENT SERVICE TYPE *

- 779 C-Section Delivery
704 Custodial Care
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
427 Rehab
402 Skilled Nursing Facility
411 Surgical
992 Transplant
720 Vaginal Delivery

(Enter the Service type number in the boxes) [Form field]

Are services needed for discharge planning? YES NO

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 Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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