

# INPATIENT AUTHORIZATION / NOTIFICATION FORM

Turnaround Time for ALL Prior Authorization Requests: 2 Business days when all information is received and 14 calendar days per COMAR when additional information is required. If you feel that your request is of an urgent nature, please submit your request via phone. All other request should go through via the fax number above. You must verify prior authorization requirements via the tool on our secure provider web portal, accessible via our website, at www.marylandphysicianscare.com to verify PA requirements before submitting the PA request. You can also submit prior authorization requests via this secure provider web portal.

**\* Indicates Required Field**

### MEMBER INFORMATION

\*Medicaid/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

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

### \*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

220 Comprehensive Inpatient Rehab Facility	414 Premature/False Labor
779 C-Section Delivery	402 Skilled Nursing Facility
479 Inpatient Rehab Hospital	411 Surgical
970 Medical	209 Transplant Surgery
300 Neonate	720 Vaginal Delivery

Please see Outpatient Prior Authorization form for observation request.



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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