Iowa Medicaid
IOWA HHS

INPATIENT MEDICAID
PRIOR AUTHORIZATION FORM

☐ **Standard Request** - Determination within **14** calendar days of receiving all necessary information.

☐ **Urgent Request** - Expedited request necessary to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function. Authorization decision will be done within **72** hours of receipt of request. **42 CFR §438.210**

***If Concurrent Request, write Authorization #**

☐ **Iowa Total Care** ☐ **Wellpoint** ☐ **Molina Healthcare** ☐ **Fee for Service**

*** Indicates Required Field**

MEMBER INFORMATION

*Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION *Address Required on Supplemental Form*

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION *Address Required on Supplemental Form*

↳ ☐ Same as Requesting Provider

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

*Primary Procedure Code

(CPT/HCPCS) (Modifier)

Start Date *OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

☐ Additional codes will be provided on Supplemental Information Form

End Date *OR* Discharge Date (MMDDYYYY)

Total Units/Visits/Days For Primary CPT Code

☐ ***Please mark if including clinical information with the request***

(Enter the Service type number in the boxes) (Iowa Total Care)

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

State form: 470-5594 (Rev. 09/25)
Rev. 01242024
IA-PAF-5876

Iowa Medicaid
Iowa HHS

MEDICAID SUPPLEMENTAL INFORMATION
PRIOR AUTHORIZATION FORM

Sheet ___ of ___

MEMBER INFORMATION

Medicaid/Member ID

Last Name, First

Date of Birth

(MMDDYYYY)

Requesting Provider Address

(Street Address) (City) (State) (Zip Code)

Servicing Provider Address

(Street Address) (City) (State) (Zip Code)

ADDITIONAL DIAGNOSIS

Diagnosis Code (ICD-10)	Diagnosis (ICD-10)	Diagnosis (ICD-10)
Diagnosis Code (ICD-10)	Diagnosis (ICD-10)	Diagnosis (ICD-10)

ADDITIONAL PROCEDURE CODES

Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/
Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/
Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/
Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/
Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/
Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/
Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/	Procedure Code (CPT/HCPCS) (Modifier)	Total Units/Visits/

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Iowa Medicaid
Iowa HHS

Inpatient Medicaid Prior Authorization Resources

WELLPOINT

Physical Health UM Fax #	800-964-3627
Behavioral Health Fax #	844-442-8016
Precertification Lookup Tool (PLUTO)	provider.wellpoint.com/iowa-provider/resources/prior-authorization-requirements/prior-authorization-lookup
Availity Login	apps.availity.com/availity/web/public.elegant.login
Contact Wellpoint (Providers)	provider.wellpoint.com/iowa-provider/home

IOWA TOTAL CARE

Iowa Total Care Portal	provider.iowatotalcare.com
Physical Health Fax #	833-257-8327
Behavioral Health Fax #	844-908-1169

Service Type

490 Boarder Baby, **414** Premature/False Labor, **492** Subacute, **779** C-Section Delivery, **720** Vaginal Delivery, **121** Long Term Acute Care, **992** Transplant, **411** Surgical, **970** Medical, **427** Rehab, **300** Neonate, **402** Skilled Nursing Facility, **528** BH Chemical Substance Abuse, **529** BH Psychiatric Admission, **527** BH RTC-MH (Psychiatric Medical Institution for Children, PMIC)

MOLINA HEALTHCARE

Availity Login	apps.availity.com/availity/web/public.elegant.login
UM Fax #	1-877-319-6828
Provider Toll Free Number	1-844-236-1464
Advanced Imaging Fax #	877-731-7218
Transplant Fax #	877-813-1206

MEDICAID FEE FOR SERVICE

Fee for Service	hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments/prior-authorization
Fax #	515-725-1356