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.

State form: 470-5594 (Rev. 02/24)
Rev. 01242024
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