INPATIENT AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:
https://secure.healthx.com/KeyCareAdvantage.Provider
Call 1-844-206-1205 (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: ☐NP/PA ☐PCP ☐Therapy Rep ☐Other		
SERVICING PROVIDER/FACILITY			
Admitting/ Servicing Facility Name:			
NPI/ TIN Number:	Phone Number:	Fax number:	
SERVICE TYPE REQUESTED			
☐Initial Request ☐Extension Request, Previous Auth #:			
Inpatient Services: (Select one)			
☐ Observation (OBS) ☐ Unplanned (via ER) Inpatient Hospital (IP) ☐ Elective/ Scheduled Inpatient Hospital (IP) ☐ Inpatient Psychiatric Care ☐ Other Inpatient:	☐ Long Term Acute Care (LTAC) ☐ Inpatient Rehabilitation Facility (IRF)	☐ Post-Acute Skilled Nursing Facility (SNF) ☐ Skill-In-Place (SIP) ☐ 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):