

**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 §438.21**

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

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

**\* Indicates Required Field**

### MEMBER INFORMATION

\*Medicaid/Member ID \_\_\_\_\_ Last Name, First \_\_\_\_\_ (MMDDYYYY) \_\_\_\_\_ \*Date of Birth \_\_\_\_\_

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

<p><b>Amerigroup</b></p> <p><b>Physical Health - Fax #: 800-964-3627</b></p> <ul style="list-style-type: none"> <li>Out of State Brain Injury Rehab</li> <li>Observation</li> <li>C-Section Delivery</li> <li>Long Term Acute Care</li> <li>Neonate</li> <li>Rehab</li> <li>Skilled Nursing Facility</li> <li>Subacute</li> <li>Vaginal Delivery</li> <li>Transplant</li> </ul> <p><b>Behavioral Health - Fax #: 877-434-7578</b></p> <ul style="list-style-type: none"> <li>Psychiatric Medical Institution for Children (PMIC)</li> <li>Chemical Substance Abuse</li> <li>Chemical Substance Abuse RTC</li> <li>Psychiatric Admission</li> <li>Partial Hospital (PHP)</li> <li>Intensive Outpatient (IOP)</li> </ul>	<p><b>Iowa Total Care</b></p> <p style="text-align: center;">(Enter the Service type number in the boxes)</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Physical Health - Fax #: 833-257-8327</b></p> <ul style="list-style-type: none"> <li>490 Boarder Baby</li> <li>779 C-Section Delivery</li> <li>121 Long Term Acute Care</li> <li>970 Medical</li> <li>300 Neonate</li> <li>414 Premature/False Labor</li> <li>427 Rehab</li> <li>402 Skilled Nursing Facility</li> <li>492 Subacute</li> <li>411 Surgical</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Behavioral Health - Fax #: 844-908-1169</b></p> <ul style="list-style-type: none"> <li>720 Vaginal Delivery</li> <li>992 Transplant</li> <li>528 BH Chemical Substance Abuse</li> <li>529 BH Psychiatric Admission</li> <li>527 BH RTC-MH (Psychiatric Medical Institution for Children, PMIC)</li> </ul> </td> </tr> </table>	<p><b>Physical Health - Fax #: 833-257-8327</b></p> <ul style="list-style-type: none"> <li>490 Boarder Baby</li> <li>779 C-Section Delivery</li> <li>121 Long Term Acute Care</li> <li>970 Medical</li> <li>300 Neonate</li> <li>414 Premature/False Labor</li> <li>427 Rehab</li> <li>402 Skilled Nursing Facility</li> <li>492 Subacute</li> <li>411 Surgical</li> </ul>	<p><b>Behavioral Health - Fax #: 844-908-1169</b></p> <ul style="list-style-type: none"> <li>720 Vaginal Delivery</li> <li>992 Transplant</li> <li>528 BH Chemical Substance Abuse</li> <li>529 BH Psychiatric Admission</li> <li>527 BH RTC-MH (Psychiatric Medical Institution for Children, PMIC)</li> </ul>
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Please mark if including clinical information with the request	<p><b>Fee for Service: Fax # 515-725-1356</b></p> <p>more information: <a href="https://dhs.iowa.gov/ime/providers/claims-and-billing/PA">https://dhs.iowa.gov/ime/providers/claims-and-billing/PA</a></p>		

**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.**

