INPATIENT ADMISSION NOTIFICATION & PRIOR AUTHORIZATION / SERVICE AUTHORIZATION REQUEST FORM

Trillium Health Resources — Utilization Management

I. MEMBER / BENEFICIARY INFORMATION	
Last name:	First name:
Medicaid ID #:	Date of birth:
Address (Street, City, State, ZIP):	

II. REQUESTING PROVIDER / FACILITY INFORMATION	
Provider / Facility name:	Network status: ☐ Network ☐ Out-of-Network
Provider TIN and NPI:	
Address (Street, City, State, ZIP):	
Name of person making request:	Phone:
Email:	Fax:

III. RENDERING PROVIDER / FACILITY INFORMATION (complete only if different from Section II)	
Facility name:	Network status: ☐ Network ☐ Out-of-Network
Facility TIN and NPI:	
Address (Street, City, State, ZIP):	
Contact person name:	Phone:
Email:	Fax:

IV. DIAGNOSIS

Primary ICD-10 diagnosis code:	Description:
Secondary ICD-10 diagnosis code:	Description:

Actual or planned admission date:

V. REQUEST TYPE

Request type:

- ☐ Acute/emergent inpatient admission
- ☐ Inpatient concurrent review
- ☐ Level of Care change (describe below)
- ☐ Elective/planned inpatient admission
- ☐ Non-covered service
- ☐ Over the benefit limit

If Level of Care change or elective/planned admission, describe / provide rationale for inpatient site of service:

VI. SERVICE INFORMATION

Ref No.	Type of Service / Procedure Code (CPT/HCPCS/Bed Type)	From	Through	Unit Type	# of Units Requested
1					
2					
3					
4					
5					
6					

VII. DETAILED EXPLANATION OF MEDICAL NECESSITY

Attach additional pages if necessary. Do not use another prior authorization form for continuation pages.

VIII. EXPEDITED REQUEST

☐ Check here if this is an expedited request because the standard review timeframe could seriously jeopardize the patient's life, health, or ability to attain/maintain/regain maximum function.

If checked, attach medical documentation clearly supporting the need for expedited review.

CERTIFICATION

By submitting this form, the requesting/prescribing provider certifies that the information provided above is true, accurate, and complete.

Provider signature:	Date: