



## INPATIENT AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:

<https://secure.healthx.com/AlignSeniorCare.Provider>

Call California: 1-844-305-3879 (TTY 711), Florida: 1-844-788-8935 (TTY 711), Michigan: 1-855-855-0336 (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:
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Date of Birth:	Member Residence:
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### REQUESTING PROVIDER/FACILITY

Requestor's Name (Print):	Phone Number:	Fax Number:	Date of Request:
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Referring Provider (If other than requestor):	Referring Provider:  <input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other
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### SERVICING PROVIDER/FACILITY

Admitting/ Servicing Facility Name:			
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NPI/ TIN Number:	Phone Number:	Fax number:
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### SERVICE TYPE REQUESTED

<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension Request, Previous Auth #:
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Inpatient Services: (Select one)			
<input type="checkbox"/> Observation (OBS) <input type="checkbox"/> Unplanned (via ER) Inpatient Hospital (IP) <input type="checkbox"/> Elective/ Scheduled Inpatient Hospital (IP) <input type="checkbox"/> Inpatient Psychiatric Care <input type="checkbox"/> Other Inpatient:	<input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Inpatient Rehabilitation Facility (IRF)	<input type="checkbox"/> Post-Acute Skilled Nursing Facility (SNF) <input type="checkbox"/> Skill-In-Place (SIP) <input type="checkbox"/> Other post-acute care:	

Days/ Visits Requested:	Admission Date/ Date of Service:
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CPT Code (or Description of service being requested):	
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Current Primary Diagnoses and ICD-10 Code(s):	
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**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):