FirstCarolinaCare

INPATIENT / POST ACUTE
PRIOR AUTHORIZATION REQUEST FORM

Please fax to (866) 896-1941

SECTION 1 – DATES / CONTACT INFORMATION

Today's Date: ____/____/____ Admit Date: ____/____/____ ❑ Standard ❑ Urgent

Person Completing Form: _____ Phone #: _(___)____-_____ Fax #: _(___)____-_____

SECTION 2 – MEMBER / PATIENT INFORMATION

Name: _____ DOB: ____/____/_____

Member ID #: _____

SECTION 3 – ADMITTING PROVIDER

Name: _____ Tax ID #: _____

Phone _(___)____-_____ NPI #: _____

SECTION 4 – ADMITTING FACILITY NAME

Name: _____ TAX ID #: _____

Diagnosis: _____ ICD 10 - Codes: _____ NPI #: _____

Procedure: _____ CPT Codes: _____

SECTION 5 – SERVICES REQUESTED

SELECT THE TYPE OF INPATIENT SERVICE REQUESTED # Days Requested: _____

❑ Acute Inpatient Hospital ❑ Behavioral Health ❑ Inpatient Rehab ❑ LTAC

❑ SNF ❑ Swing Bed ❑ Transplant (Organ, Bone Marrow) - select -

CHECK ONE: ❑ Pre-admission Request ❑ Notification of Admission

SECTION 6 – OUT OF NETWORK REQUESTS

Reason for Request:

❑ Not Available in Network ❑ Urgent / emergent ❑ Member Request

❑ Other (*please specify*): _____

SECTION 7 – FOR HOSPITAL TO HOSPITAL TRANSFER

ENTER NAME OF FACILITY MEMBER IS BEING TRANSFERRED FROM: _____

REASON / RATIONALE FOR TRANSFER: _____

SECTION 8 – ADDITIONAL INFORMATION

Please add special instructions below. Attach ALL pertinent clinical information (i.e. Office visit notes, imaging, labs)