



INPATIENT AUTHORIZATION FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:
<https://secure.healthx.com/LagniappeAdvantage.Provider>
 Call 1-844-217-0052 (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: <input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other		

SERVICING PROVIDER/FACILITY

Admitting/ Servicing Facility Name:		
NPI/ TIN Number:	Phone Number:	Fax number:

SERVICE TYPE REQUESTED

<input type="checkbox"/> Initial Request		<input type="checkbox"/> Extension Request, Previous Auth #:	
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:	
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):