www.amerihealthcaritasia.com

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) and Nursing Facilities Prior Authorization and Concurrent Review Request Form

Fax completed form and all pertinent clinical information related to your request for long-term inpatient prior authorization to **1-844-399-0479**.

Please complete all appropriate fields.

Patient information
Patient Medicaid number:
Date of birth:
Patient name:
Address:
City/State/ZIP code:
Patient/guardian phone:
PMP name:
PMP NPI:
PMP phone:
Ordering, prescribing or referring (OPR) provider information
OPR physician NPI#:

Requesting provider information
Requesting provider NPI#:
Tax ID#:
Provider name:
Rendering provider information
Rendering provider NPI#:
Tax ID#:
Name:
Address:
City/State/ZIP code:
Phone:
Fax:
Preparer's information
Name:
Phone:
Fax:

Service start date	Requested service code	Requested duration

Is the member currently on a waiver? ❏ Yes ❏ No	Does the member have an assigned case manager? ❏ Yes ❏ No
What is the member's current location (i.e., home, hospital)?	
Will this be a permanent move or temporary placement for the member?	

Notes:

Please note: Your request **must** include medical documentation to be reviewed for medical necessity.
Submit only one member per prior authorization request form.
This form is for use when requesting initial long-term facility admission.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Provider signature:	Date:

ACIA-16506