



Prior Authorization Request Form

Acute, Residential, RSPD

Provider Information			
Date Submitted:		Initial •	Concurrent •
Facility Name:		Admitting /Referring Provider	
Facility NPI:		Admitting/Referring NPI:	
Tax ID (TIN):		Facility Address:	

Institutional/Behavioral Health Case

Member Name:		Date of Birth :	
CareSource PASSE ID#:		Medicaid ID:	
ICD-10 Diagnosis Code (s):		Diagnosis Description:	

Guardianship: Yes • No

<ul style="list-style-type: none"> Acute Psych Inpatient <p>Authorization Guidelines: varies considering MCG criteria, clinical and social factors.</p>	<ul style="list-style-type: none"> Psychiatric Residential Facility <p>Authorization Guidelines: 30-day authorization periods; after 180 days 14-day authorizations</p>	<ul style="list-style-type: none"> Rehabilitative Services for Persons with Physical Disabilities
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Disclaimer: An authorization is not a guarantee of payment; Member must be eligible at time of services rendered.

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