Vaya Partners

# Physical Health Inpatient Admission Notification and Service Authorization Request Form

Use this form to notify Vaya Partners of inpatient admission and concurrent review authorization requests if you are unable to access Vaya Partners' provider portal, ProviderCONNECT. When possible, Vaya Partners strongly prefers service authorization requests (SARs) be submitted through ProviderCONNECT.

## Submission Requirements

- **Fax completed forms to 828-707-9356.**
- **Do not combine forms and records for multiple patients in one fax.** Per Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, send separate faxes for each patient.

| DO NOT USE THIS FORM FOR: | INSTEAD, USE THE: |
|---|---|
| **Post-acute facility admissions,** *e.g., Skilled Nursing Facility (SNF), Subacute Rehabilitation, or long-term acute care hospital (LTACH)* | Post-Acute Facility Service Authorization Request Form on our Prior Authorization webpage |
| **Behavioral health, intellectual/developmental disability (I/DD), and traumatic brain injury (TBI) authorization requests** | Behavioral Health Service Authorization Request Form on our Prior Authorization webpage |

All requests must be accompanied by supporting medical records, including physicians' orders, notes, test results, etc. Failure to provide complete information and required medical records will result in authorization delays. For more information, visit the Authorization Guidelines page of Vaya Partners' ProviderCENTRAL website.

## Member Information

Last name: _____ First name: _____

Medicaid ID #: _____ Date of birth: _____

## Requesting Provider/Facility Information

Provider name: _____ ☐ Network provider ☐ Out-of-network provider

Provider TIN: _____ Provider NPI: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Name of person making request: _____ Phone: _____

Email: _____ Fax: _____


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## Servicing Provider/Facility Information

Complete this section only if the facility is not the same as the requesting provider/facility.

Facility name: _____ ☐ Network provider ☐ Out-of-Network provider

Facility TIN: _____ Facility NPI: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Contact person name: _____ Phone: _____

Email: _____ Fax: _____

## Request Information

**Diagnoses**

ICD-10 diagnosis code: _____ Description: _____

Second ICD-10 diagnosis code: _____ Description: _____

Actual or planned admission date: _____

**Request Type**

☐ Acute/emergent inpatient admission

☐ Inpatient concurrent review

☐ Level of Care change (describe): _____

☐ Neonatal intensive care unit (NICU) or sick baby notification:

Birthing parent's full name: _____ Birthing parent's date of birth: _____

Newborn's full name: _____ Newborn's date of birth: _____

☐ Elective/planned inpatient admission

If you are requesting an elective/planned inpatient admission for a procedure, explain the rationale for the inpatient site of service:


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| Type of Service | Service Code (CPT/HCPCS/BED TYPE) | Start Date | Unit Type | # of Units Requested |
|---|---|---|---|---|
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Additional information (optional):

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## Expedited Requests

☐ Check this box for an **expedited request** if the standard time for making a determination could seriously jeopardize the life or health of the patient or seriously jeopardize the patient's ability to attain, maintain, or regain maximum function.

If you check the box above, you must submit medical documentation that clearly supports the need for an expedited request.

**By submitting this form, the requesting provider certifies that the information given is true, accurate, and complete.**


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