Prior Authorization Request Form – INPATIENT

Please fax to: 1-866-234-7230 (Inpatient Notification)
1-888-454-0024 (Skilled Nursing) | Phone: 1-888-454-0013

⁎ Required Field – please complete all required fields to avoid delay in processing

Note: In an effort to process your request in a timely manner, please submit any pertinent clinical information (i.e. progress notes, treatment rendered, test/lab results or radiology reports) to support the request for services. Any request for a non-contracted provider must include documentation to substantiate the reason for the request. **(When all required information has been submitted we will complete your request within 5 business days.)**

☐ Expedited – defined as ***danger to a member's health if not provided within 72 hours.*** Please explain:

Member Information:

***Member Name:**		
***Member DOB:** / /	***Member ID:**	***Date of Service:** / /

Requesting Provider Information:

***PCP/Requesting Provider:**	Contact Person: ***Phone #:** ***Fax #:**

Referring to (servicing) provider information: if below fields are not answered, Bravo Health will automatically assign Bravo Health's participating provider network to the member:

***Servicing Provider:** ☐ Non-contracted Tax ID #: NPI#:	Contact Person: ***Phone #:** ***Fax #:**
***Facility:** ☐ Non-contracted Tax ID #: NPI#:	Contact Person: ***Phone #:** ***Fax #:**

If requesting a non-contracted provider/facility, please explain why:

***Type of Service:** **Please check only one of the boxes:**	☐ Inpatient Emergent Notification ☐ Skilled Facility ☐ Inpatient Rehab Admit

Clinical Information:

***Diagnosis Code:**	Diagnosis:	
***Procedure/Service Requested:**	☐ CPT Code:	☐ HCPCS Code:
Procedure/Service Description:		
Number of visits:	Duration:	
Frequency of visits:	Number of previous visits:	
***Is supporting Clinical Information Attached?**	☐ Yes ☐ No - Please summarize clinical information below	