ambetter FROM | absolute total care

INPATIENT AUTHORIZATION FORM

Complete and Fax to: 1-844-560-0799

☐ **Standard requests -** Determination within 15 calendar days of receiving all necessary information.

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

***Indicates Required Field**

MEMBER INFORMATION

*Date of Birth: 03051987 (MMDDYYYY)

*Member ID: U718385410101

Last Name, First: WILLIAMS, AMANDA

REQUESTING PROVIDER INFORMATION

*Requesting NPI: 1083063507

*Requesting TIN:

Requesting Provider Contact Name:

Requesting Provider Name: BENJAMIN VELKY

Phone: 8647254865

*Fax:

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ Same as Requesting Provider

*Servicing NPI: 1023046612

*Servicing TIN: 570331865

Servicing Provider Contact Name: UR DEPT

Servicing Provider/Facility Name: SELF REGIONAL HE

Phone: 8647255039

Fax: 8647255044

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date OR** Admission Date: 04242025 (MMDDYYYY)

*Diagnosis Code: K57.92 (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)

Additional Diagnosis Code (ICD-10)

*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) 970

Delivery
779 C-Section Delivery
720 Vaginal Delivery

Rehab
427 Rehab

Transplant
992 Transplant

Miscellaneous
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
490 Boarder Baby
300 Neonate

Behavioral Health
528 BH Chemical Substance Abuse
529 BH Psychiatric Admission
531 BH Eating Disorders
532 BH Crisis Stabilization Unit
535 BH Residential Treatment - Substance Use
536 BH Residential Treatment - Mental Health

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

04/25/2025 12:26PM (GMT-05:00)

Received by Centene: 2025-04-25 12:25:50 CST

SELF REGIONAL HEALTHCARE

Important - Utilization Review from Self Regional Healthcare

Apr 25 2025 1:07PM ET

Dear ,

Utilization Review ADM - 175174453 information for AMANDA WILLIAMS, Patient Account # 10001431398 is included in this fax. Please use the contact information below to discuss any questions with this review.

Fax Comment:
CLINICAL INFO ATTACHED- PLEASE FAX IP AUTH/APPROVED IP DAYS TO
864-725-5044

LETTER OF IP SUPPORT ATTACHED

AMBETTER ATC PRECERT INFO-IP COMPLETED IP AUTH FORM AND SCANNED FOR UR DEPT TO SEND WITH CLINICALS FAX # 844-560-0799

Contact Information:
Tammie Foster
Phone: (864) 725-5039

Thank you.

Authorization Number Request

Use Fax Number (864) 725-5044 to fax authorization number for approval for above patient

Authorization # _____