Inpatient Hospital Admission Pre-Authorization Request Form

Patient Information

Full Name

Date of Birth

Member/Policy Number

Phone Number

Address

Provider Information

Referring Provider Name

NPI Number

Provider Phone

Facility Name

Facility Address

Admission Details

Admission Date

Type of Admission

Expected Length of Stay (Days)

Clinical Information

Primary Diagnosis

Reason for Admission / Clinical Justification

Treatment Plan

Insurance Information

Primary Insurance

Group Number

Authorization Number

Additional Information

Comments