PeakHealth

Inpatient Authorization Form

Please provide the information below for the member.

Member ID Number:		**Member Group Number (Optional):**
Member Last Name:	**Member First Name:**	**Member Date of Birth: (MM/DD/YYYY):**
Member Address:		**Member Phone Number:**

Request Type: ☐ Pre-Service ☐ Post-Service ☐ Concurrent

Referral # (If any): _____

Type of Admission: ☐ IP ☐ SNF ☐ Rehab ☐ LTAC ☐ BH-IP ☐ BH- Detox ☐ BH- Res

Other (Please List): _____

Requesting Provider's Name:	**Requesting Provider's NPI:**	**Contact Person:**
Contact Person Phone Number:		**Contact Person Fax Number:**

Treating Provider's Name:	**Treating Provider's NPI:**
Treating Provider's Phone Number:	**Treating Provider's Fax Number:**
Facility Name:	**Facility TIN/NPI:**
Facility's Address:	
Facility Phone Number:	**Facility Fax Number:**

Are you requesting an expedited review: ☐ Yes ☐ No

To allow us to review and respond to your request, please provide the following information.

Bed Type:	**Date of Admission:**
Expected Length of Stay or Discharge Date:	**Discharged to (if applicable):**
Diagnosis Code(s) and Procedure Code(s):	
Additional Details for request:	

Note: To obtain a review, submit this form and any supporting documentation that would be helpful in the evaluation of your request including invoices, correspondence, medical records, or other clinical documents related to the service requested.

You may submit a referral electronically via Epic or the PeakProvider Secure Portal

Information may also be submitted by fax or by mail:

Peak Health Utilization Management Department

P.O. Box 4262

Morgantown, WV 26504

Fax: 304-974-3191

If requesting an expedited review or for assistance with completing this form, please contact Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325), Monday through Friday, 8:00am to 5:00pm ET, excluding holidays.