Priority Health

Medical emergent inpatient prior authorization form

Missing or incomplete information, including required clinical documentation, may result in delays.
Don't use this form for elective/planned inpatient admissions – *instead use the* _Medical Prior Authorization Form_.

This form is for out-of-network providers only. In-network providers must use GuidingCare.

☐ Check if requesting on behalf of a Cigna-participating provider

Date of request: _____

Type of service: Emergent inpatient – *prior authorization isn't required for observation*

Priority

Emergent admission   Retrospective admission

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	

Date of admission		Estimated length of stay	
Diagnosis code(s)		Diagnosis – *description*	
Revenue code(s)		Bed type	

Facility information

Facility name					
Facility TIN		Facility address			
Facility NPI					
Contact name		Phone		Fax	

Describe the admission reason and/or your request to add additional days to an existing authorization:

You must send medical records with your request including H&P, labs, medication record, imaging and MD/DO documentation. Your request won't be processed without this information.

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