Highmark Blue Shield
Medical Management and Policy Department
Inpatient Authorization Request Form

Submission Instructions:
Please print all information.
IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS.**
Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.

Please fax to the Medical Management and Policy Department: **800.416.9195 or 877.650.6069** (*Delaware Only*)

Name of Requestor/Contact Person		
Requestor's Phone Number		
Member ID Number		
Patient Name		
Patient Phone Number		
Gender	☐ Male ☐ Female	Patient DOB:
Patient Address	Street: City: State: Zip Code:	
Type of Service (i.e., INPT/OBS/SPU)		
Date of Admission or Service/ Length of Stay		
Type of Admission	Urgent ☐ Emergency ☐ Elective ☐	
Facility Name		
Facility Address	Street: City: State: Zip Code:	
NPI Number		Bed Type:
Admitting /Treating Physician's Name		
NPI Number		
Admitting/Treating Physician's Address	Street City: State: Zip Code:	
Diagnosis Code(s) & Procedure Code(s)		

Clinical Information/Comments *(please attach additional **pertinent** clinical documentation)*:

Discharge Plan: