Instructions for Prior Authorization Review Form for Elective CABG

This information must be communicated to the hospital for elective CABG

all requests need to be submitted online by the hospital at least three days prior to admission

|  |
| --- |
| Request Date |

* ***Request Date*** - Enter the date of submission of the request.

|  |
| --- |
| Participant Information |

* ***Participant Name*** - Enter the Participant’s last, first and middle name as it appears on the IL Medicaid ID card.
* ***Date of Birth*** - Enter the month, date, and year of the Participant’s birth.
* ***Participant Medicaid Number*** - Enter the Participant’s nine (9) digit number that appears on the IL Medicaid identification card*.*
* **Sex** - Indicate the sex of the Participant.
* ***Age*** - Enter the age of the Participant at the time service is to be rendered.

|  |
| --- |
| Hospital/Requestor Information |

* ***Hospital’s Name*** - Enter the name of the hospital to which the Participant will be admitted.
* ***Hospital IL Medicaid Provider Number*** - Enter the hospital’s Illinois Medicaid provider number.
* ***Hospital Requestor’s Name*** - Enter the name of the individual completing the review form.
* ***Hospital Requestor’s Telephone Number and Ext.*** - Enter the telephone number of the contact, including area code and extension number.
* ***Hospital Requestor’s e-mail*** - Enter the e-mail address of the contact individual.

|  |
| --- |
| Attending (Surgeon) Information |

* ***Physician’s Name*** - Enter the name of the attending (surgeon) physician, last, first and middle initial.
* ***Physician’s Address***- Enter the street address, city, state and zip code of the physician.
* ***Physician’s Phone Number*** - Enter the phone number of the physician.
* ***Physician’s Medicaid Number***- Enter the physician’s Medicaid number.

|  |
| --- |
| Preadmission Information |

* **(Proposed) Admission Date** - Enter the proposed date of admission for the procedure.
* ***ICD-9-CM Diagnosis Code(s)*** - Enter the ICD-9-CM code(s) and narrative description(s) for the Participant’s primary diagnosis.
* ***Date(s)/ICD-9-CM Code(s)/Procedure(s)*** - Enter date of planned procedure(s), the ICD-9-CM procedure code(s) and procedure narrative description(s).

|  |
| --- |
| Clinical Findings |

* ***Clinical Indications*** - Mark the appropriate clinical indications for the planned procedure.

|  |
| --- |
| Past Treatments |

* ***Previous treatments*** - List results of any treatments not described in clinical indications section.

|  |
| --- |
| Labs/Studies/Tests/X-ray/Imaging |

Enter date and results of pertinent labs, studies, tests, x-rays and imaging that may be necessary to complete prior authorization review.

Ad

|  |
| --- |
| Additional Comments |

Additional space is provided for provision of any additional information you believe will support that the planned procedure is medically necessary. **It is not necessary to repeat any information previously documented.**

omments