Vaya Health

Physical Health Inpatient Admission Notification and Service Authorization Request Form

Use this form to notify Vaya Health (Vaya) of inpatient admission and concurrent review authorization requests if you are unable to access Vaya's Provider Portal. When possible, Vaya strongly prefers service authorization requests (SARs) be submitted through the Provider Portal.

Submission Requirements

- **Fax completed forms to 828-707-9356.**
- **Do not combine forms and records for multiple patients in one fax.** Per Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, send separate faxes for each patient.

DO NOT USE THIS FORM FOR:	INSTEAD, USE THE:
Post-acute facility admissions, *e.g., Skilled Nursing Facility (SNF), Subacute Rehabilitation, or long-term acute care hospital (LTACH)*	Post-Acute Facility Service Authorization Request Form on our Prior Authorization webpage
Behavioral health, intellectual/developmental disability (I/DD), and traumatic brain injury (TBI) authorization requests	Behavioral Health Service Authorization Request Form on our Prior Authorization webpage

All requests must be accompanied by supporting medical records, including physicians' orders, notes, test results, etc. Failure to provide complete information and required medical records will result in authorization delays. For more information, visit the Authorization Guidelines page on Vaya's Provider Central website.

Member Information

Last name: _____ First name: _____

Medicaid ID #: _____ Date of birth: _____

Requesting Provider/Facility Information

Provider name: _____ ☐ Network provider ☐ Out-of-Network provider

Provider TIN: _____ Provider NPI: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Name of person making request: _____ Phone: _____

Email: _____ Fax: _____

Servicing Provider/Facility Information

Only complete this section if the facility is not the same as the requesting provider/facility.

Facility name: _____ ☐ Network provider ☐ Out-of-Network provider

Facility TIN: _____ Facility NPI: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Contact person name: _____ Phone: _____

Email: _____ Fax: _____

Request Information

Diagnoses

ICD-10 diagnosis code: _____ Description: _____

Second ICD-10 diagnosis code: _____ Description: _____

Actual or planned admission date: _____

Request Type

☐ Acute/emergent inpatient admission

☐ Inpatient concurrent review

☐ Level of Care change (describe): _____

☐ Neonatal intensive care unit (NICU) or sick baby notification:

Birthing parent's full name: _____ Birthing parent's date of birth: _____

Newborn's full name: _____ Newborn's date of birth: _____

☐ Elective/planned inpatient admission

If you are requesting an elective/planned inpatient admission for a procedure, explain the rationale for the inpatient site of service:

Type of Service	Service Code (CPT/HCPCS/BED TYPE)	Start Date	Unit Type	# of Units Requested

Additional information (optional):

Expedited Requests

☐ Check this box for an **expedited request** if the standard time for making a determination could seriously jeopardize the life or health of the patient or seriously jeopardize the patient's ability to attain, maintain, or regain maximum function.

If you check the box above, you must submit medical documentation that clearly supports the need for an expedited request.

By submitting this form, the requesting provider certifies that the information given is true, accurate, and complete.