Inpatient Admission/Concurrent Review Request FEP only - Alaska

Instructions

- Handwritten faxes not accepted.
- Download this form to complete it.
- Use the following FEP fax number: **866-948-8823.**
- This form must be the first two pages of the fax submission.

Please note

- **Admission notification:** Prior authorization required for all admissions
- **Observation notification:** No notification needed – Do not submit a form
- **Maternity admission:** Precertification is required only if the patient's stay is over 48 hours for vaginal birth or 96 hours for a C-section, from the date of delivery.
- **Discharge notification:** Required upon discharge
- If authorization for a stay is not obtained but inpatient level of care is determined to be medically necessary, payment for the stay will be reduced by $500.

A. Member/patient information

Member/patient name			Date of birth
Member ID number details	Enrollment code	Member ID Number	
NICU only	Birth mother's name	Baby gender	☐ Twins

B. Urgent request: Note scheduling issues do not meet the definition of urgent. Services more than five days out are not considered urgent.

☐ Check this box if this is an urgent request.

Urgent requests **must be signed by the requesting provider** and include supporting documentation from the provider's office. It must be noted that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, or
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

MD Signature: **I attest that this request meets the urgent definition described above.**	Print name	
X _____	Print title	Date signed

C. Facility information: Every field in this section is required.

Facility Name			
Facility address	City	State	ZIP code
Phone number with area code	Fax number with area code		
TIN number	NPI number		

058254 (07-01-2026)

Contact person	Phone number with area code
Related prior authorization number (if applicable)	

D. Admission

Admit date	Discharge date (If applicable)
ICD 10 Diagnosis code	Procedure code (CPT) – Required for Surgical Admissions

E. Admitting Physician

Physician name		☐ Hospitalist (Address same as facility) ☐ Not a Hospitalist (Address required below)	
Address	City	State	Zip code
Tax ID (required):		NPI # (required)	

F. Substance Use Disorder Providers

Part 2 providers must obtain written patient consent (TPO consent) before submitting claims or medical necessity review for substance use disorder (SUD) services or sharing SUD related information. Please confirm that the required written patient consent has been obtained by checking "Yes" below.

☐ Yes, I attest we have received written consent to share SUD related information.

G. Type of Admit (check only one)

Med/Surg Inpatient
☐ Medical
☐ Surgical
☐ Neonatal intensive care unit (NICU)

Med/Surg Lower Levels of Care:
☐ Inpatient rehab (IPR)
☐ Neuro rehab
☐ Skilled nursing (SNF)
☐ Long-term acute care (LTAC)

BH Inpatient
☐ Detox (ASAM Level 4.0 – WM)
☐ Psychiatric
☐ Eating disorder
☐ Substance use (ASAM Level 4.0)
☐ Substance use rehabilitation (ASAM Level 3.7)

BH Lower Levels of Care
☐ Residential treatment center (RTC) – Detox (ASAM Level 3.7 - WM)
Residential Treatment Center (RTC) – Choose below:
☐ Mental health ☐ Eating disorder
☐ Substance use (ASAM Level 3.3-3.5)

This precertification is based on diagnosis and medical information submitted and is subject to all contract terms, including, but not limited to, member benefits, benefit maximums and subscription charge payment covering dates of service. Unless specifically requested elsewhere in this document, please do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

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