Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Induction of Labor Prior to 39 Weeks

Upload this request through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

Purpose: A hospital will use this form to request authorization for an induction of labor before 39 weeks.

DATE OF REQUEST: _____/_____/_____

NOTES:

RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Address:		Phone:
City:	State:	Zip Code:
Guardian Name (*if applicable*):		Guardian Phone:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	

ORDERING PROVIDER INFORMATION		
Ordering Provider Name:		NPI:
Address:		Contact Name:
City:	State:	Zip Code:
Phone:		Fax:

SERVICING PROVIDER INFORMATION *(facility)*		
Facility Name:		NPI:
Facility Address:		Contact Name:
City:	State:	Zip Code:
Phone:		Fax:

CLINICAL INFORMATION		
Estimated Admission Date:	Estimated Length of Stay: _____ days	Estimated Discharge Date:

Admission Diagnosis	**Description**
1.	
2.	
3.	
Revenue Code	**Description**
1.	

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2.	
3.	
Requested Procedures	**Description**
1.	
2.	
3.	
Other Requested Services	**Description**
1.	
2.	
3.	
Please provide appropriate clinical information to support your request	
EDC:	Gestational age at date of induction (week+day):

EDC based on:

☐ US 10-20 weeks ☐ Doppler FHT+ for 30 weeks ☐ +hCG for 36 weeks

☐ Other dating criteria (by ACOG Guidelines, women should be 39 weeks or greater before initiating an elective (no indication) delivery. ACSG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery):

☐ Fetal Lung Maturity test result:	Date:

Early Induction of Labor Indications: *(check all that apply)*

Obstetric and Medical Conditions:

☐ Chronic HTN	☐ Coag/Thrombophilia	☐ Diabetes (Type I or II)	☐ Fetal Demise (current)
☐ Fetal Demise (prior)	☐ Fetal Malformation	☐ GDM with insulin	☐ Gestational HTN
☐ Heart Disease	☐ HIV	☐ Isoimmunization	☐ IUGR
☐ Liver Disease (e.g., cholestasis of pregnancy)	☐ Oligohydramnios	☐ Polyhydramnios	☐ Preeclampsia
☐ Previa	☐ PROM	☐ Pulmonary Disease	☐ Renal Disease
☐ Twin with complication	☐ Other:		

If “Other” chosen, then enter name of perinatology consult who agrees with plan:

Elective Induction (≥ 39 weeks) Indications:

☐ Distance *(please specify):*

☐ Macrosomia	☐ Patient Choice/Social	☐ Other

If “Other” chosen, please specify:

Indication’s description/details:

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Severity of Illness (signs and symptoms, abnormal lab or other test findings):
Intensity of Service (plan of treatment including diagnostic and other services):
Discharge Plan:

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged, confidential and only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.