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.	

Induction of Labor Prior to 39 Weeks

Recipient Name:_____ Date of Request:_____

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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Recipient Name:_____ Date of Request:_____

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: