

How to create a preauthorization – Inpatient case

Provider logs into the web portal.

On Left navigational pane- Select Prior Approval

Click on the options to create a preauthorization. The screen will look for the provider when they login with their credentials. Click Next.

Welcome, [Redacted] | [Change PIN](#) | [Log Out](#) | AAA |

EmblemHealth

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Providers

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NEWS & FEATURES

PROVIDER RESOURCES

DENTAL PROVIDER RESOURCES

GHI PPO members (other than City of New York) are being migrated to our new claims platform. Members will be transitioned when their plan renews. Please ask your patients for their current member ID card at each appointment. Please submit pre-authorization requests and claims using the applicable member ID that is in effect on the date of service. The following changes apply once members are on the new system:

- **[Identifying migrated members](#)**
- **[Radiation therapy & cardiology imaging programs](#)**
- **[HIP radiology self-referral payment policy will apply to migrated GHI PPO members](#)**
- **[Anesthesia claims](#)**

[Annual Provider Notification Materials](#)

[EmblemHealth 2020 Network Benefits Table](#)

[EmblemHealth Reduces Preauthorization Requirements](#)

[2020 Infertility Mandate PA Coding](#)

Personal Information

[Redacted]

Email: N/A

[Change Email](#)

How Can We Help You?

- [Check eligibility and benefits](#)
- [Check claim status](#)
- [Check pre-certification/prior approval](#)
- [Electronic Funds Transfer/ Electronic Remittance Advice](#)
- [ADA Dental Claim Form](#)
- [UB04-Hospital Claim Form](#)

Remaining Specialty Visits

[View available benefits and number of visits used for allergy, chiro and more](#)

Resources

- [Find in network-physicians, hospitals and other facilities and services for your patients.](#)
- [Free: Copy of *The Medical Manual for Religio-Cultural Competency*](#)
- [EmblemHealth Provider Manual](#)
- [More Resources](#)
- [Cultural Competency Continuing Education and Resources](#)

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Close Window

Providers

Please select the Requesting Provider.

myEmblemHealth

- Referrals
- **Prior Approvals**
- Search Referrals and Prior Approvals
- Request ER Notification
- Search ER Notification
- Preauthorization Check

Prior Approval Request

Emblem User: [Redacted]

For **Physical/Occupational Therapy** for members delegated to Palladian, requiring Prior Approval after the initial evaluation, please contact Palladian at www.palladianhealth.com/providers or call 1-877-774-7693 for questions. **Speech Therapy** requests for restorative services do not require a referral or prior approval for claim payment.

Inpatient Services	For all Admission Types including Medical, Surgical, Rehab SNF and Mental Health.
Outpatient Services	For all Outpatient Services including but not limited to Outpatient Clinics, Surgery and Ambulatory Surgical Centers.
Office Services	For services requiring Prior Approval to be performed by a physician or other health care professional in an office setting. Routine services with an authorized referral from the requesting provider do not require a prior approval. Simply use the authorization number of the referral issued by the requesting provider on your claim submission.
Home Care	To request Home Health Care Services.
Durable Medical Equipment	To request Durable Medical Equipment.
Transportation	To request Transportation.


Select your entity:

Entity: H/CAREMGR/ [Dropdown Arrow]

Requesting Provider:

Enter Pris # or NPI [Redacted] Next

Enter Member ID and click search. The member details will be prepopulated. Click on the drop down for the Facility code and choose the Place of Service. Select place of service where services are going to be rendered.

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Providers


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Prior Approval Request for Inpatient Facility


Requesting Provider [REDACTED]



LOS: From **Wednesday, 03/18/2020** to **Thursday, 03/19/2020** for **1** day(s)
Please enter Facility Code and Release of Info.

Admission Date*:   (mm/dd/yyyy)

of Days*: 

End Date*:   (mm/dd/yyyy)

Admission Type: 

Member ID*: [REDACTED]  

Name: [REDACTED]

Sex: [REDACTED]



Birthdate: [REDACTED]

Plan: [REDACTED]

LOB: [REDACTED]


Medical Group Name: [REDACTED] CPNY

Medical Group Number: [REDACTED]

Facility Code*: 
 


Release of info*:



Received Via*:

Notify Date*:  (mm/dd/yyyy)


Please provide contact information so that HIP may address any clinical issues required to complete a review of this case.

Contact Information

Contact Name*: 

Contact Telephone*: - -  ext: 

or

Contact Fax*: - - 

Information Not Available

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Enter Received Via from the dropdown.

Enter the date Notified of the information.

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Enter Contact information and click Next.



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Prior Approval Request for Inpatient Facility

Requesting Provider: [Redacted]

LOS: From Wednesday, 03/18/2020 to Thursday, 03/19/2020 for 1 day(s)

Please enter Facility Code and Release of Info.

Admission Date*: 03/18/2020 (mm/dd/yyyy)

of Days*: 1

End Date*: 03/19/2020 (mm/dd/yyyy)

Admission Type: Elective (3)

Member ID*: [Redacted]

Name: [Redacted]
Sex: [Redacted]
Birthdate: [Redacted]
Plan: [Redacted]
LOB: [Redacted]
Medical Group Name: [Redacted]
Medical Group Number: [Redacted]

Facility Code*: Inpatient Hospital (21)

Release of info*: Yes, Provider has a Signed Statement (Y)

Received Via*: Phone

Notify Date*: 03/17/2020 (mm/dd/yyyy)

Please provide contact information so that HIP may address any clinical issues required to complete a review of this case.

Contact Information

Contact Name*: [Redacted]

Contact Telephone*: [Redacted] ext: [Redacted]

or

Contact Fax*: [Redacted]

Information Not Available

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Select Type of Service needed



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Prior Approval Request for Inpatient Facility

Requesting Provider: [Redacted]

Certification Type: Initial

Service Type*: Info

Enter the Facility PRIS # / NPI or Search:

Facility PRIS # or NPI*:

Name:

Location:

Diagnosis:
 Enter diagnosis code. To add more than one diagnosis, enter the code and click Add. To search for a diagnosis, click Search. To clear all codes, click Clear All. To delete a code, click Delete next to the description.

#	Code	Description	
*	<input type="text"/>	<input type="text"/>	Add

LOS: From **Wednesday, 3/18/2020** to **Thursday, 3/19/2020** for 1 day(s)


Comments (Max: 500 characters):
 This Comments area may be used to document information that is specific to the requested service. Only procedure codes or services that are requested in this transaction should be referenced. These Comments are for internal use only and will not display for external users who inquire on the case's status.

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* Required Field
 Click on the Info for field information.

Enter Bedtype. Enter members diagnosis code by ICD10 code.

Enter Procedure code and units. Dates of Service will auto fill. Enter notes in Comments section if any.


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Prior Approval Request for Inpatient Facility

Requesting Provider [REDACTED]

Certification Type: Initial

Service Type*: Surgical (2) Info

Bed Type:
 ICU/CCU (ICU)
 Medical/Surgical (MD)
 Obstetrics (OB)
 Observation (OS)
 Telemetry (TEL)

Facility PRIS # or NPI*:

Name:

Location:

Diagnosis:
 Enter diagnosis code. To add more than one diagnosis, enter the code and click Add. To search for a diagnosis, click Search. To clear all codes, click Clear All. To delete a code, click Delete next to the description.

#	Code	Description	
*	<input type="text"/> Info		Add

LOS: From Wednesday, 3/18/2020 to Thursday, 3/19/2020 for 1 day(s)

Procedure(s) and/or Service(s):
 To add procedures and/or services, enter the Code and Units. To add up to four modifiers to the code, use the drop down boxes. To add additional codes, click Add. To search for a procedure or modifier, click Search. To clear all procedures and modifiers, click Clear All. To remove a procedure and any modifiers attached to the procedure, click Delete next to the description.

#	Code	Units	Description	Weight (in gms)	Modifier	
*	<input type="text"/> Info	<input type="text"/> Info		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Add

Additional Physician: No Yes

Comments (Max: 500 characters):
 This Comments area may be used to document information that is specific to the requested service. Only procedure codes or services that are requested in this transaction should be referenced. These Comments are for internal use only and will not display for external users who inquire on the case's status.

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* Required Field

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Enter who will be providing the services by Pris # or NPI number. If you use NPI number a screen will appear with the Facility name, address and pris #. Please select the appropriate provider location.

Search feature can be used.

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Prior Approval Request for Inpatient Facility

Requesting Provider: [Redacted]

Certification Type: Initial
 Service Type*: Surgical (2) [Info]
 Bed Type: Medical/Surgical (MD)

Enter the Facility PRIS # / NPI or Search for a facility.
 Facility PRIS # or NPI*: [Redacted] [Info]
 Name: [Redacted]
 Location: [Redacted]

Diagnosis:
 Enter diagnosis code. To add more than one diagnosis, enter the code and click Add. To search for a diagnosis, click Search. To clear all codes, click Clear All. To delete a code, click Delete next to the description.

#	Code	Description	
1	M16.9	OSTEOARTHRITIS OF HIP UNSPECIFIED	Delete
*	* [Input] [Info]		Add

LOS: From Wednesday, 3/18/2020 to Thursday, 3/19/2020 for 1 day(s)

Procedure(s) and/or Service(s):
 To add procedures and/or services, enter the Code and Units. To add up to four modifiers to the code, use the drop down boxes. To add additional codes, click Add. To search for a procedure or modifier, click Search. To clear all procedures and modifiers, click Clear All. To remove a procedure and any modifiers attached to the procedure, click Delete next to the description.

#	Code	Units	Description	Weight (in gms)	Modifier
1	27130	1	TOTAL HIP ARTHROPLASTY	--	Delete
*	[Input] [Info]	[Input] [Info]		[Dropdown] [Dropdown]	Add

Procedure Detail(s) for 27130:

#	From Date	To Date	Requested Units
1	* 3/18/2020	* 3/18/2020	* 1

Additional Physician: No Yes

Comments (Max: 500 characters):
 This Comments area may be used to document information that is specific to the requested service. Only procedure codes or services that are requested in this transaction should be referenced. These Comments are for internal use only and will not display for external users who inquire on the case's status.
 Test note

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A review screen will appear with all valued information. Review and hit edit if needed, if not select submit.

myEmblemHealth

Prior Approval Details Review

Your Prior Approval Request for Inpatient Facility has not yet been submitted.
Please review the information below and click the "Submit" button to send.

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- [Search Referrals and Prior Approvals](#)
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Review Type: Inpatient Facility

Category: Admission Review

Certification: Initial

Member ID: [REDACTED]

Member Name: [REDACTED]

Member Sex: [REDACTED]

Member DOB: [REDACTED]

Member Plan: [REDACTED]

Member PCP: [REDACTED]

Member PCP Phone: [REDACTED]

Member Eligibility Date: [REDACTED]

Managing Entity: [REDACTED]

Requesting Provider: [REDACTED]

Contact Name: [REDACTED]

Contact Phone: [REDACTED]

Contact Fax: [REDACTED]

Facility: [REDACTED] Hospital

Service Type: Surgical (2)

BedType: Medical/Surgical (MD)

Admission Date: 3/18/2020

Notify Date: 3/17/2020

Facility Code: Inpatient Hospital (21)

Release of info: Yes, Provider has a Signed Statement (Y)

Admission Type: Elective (3)

Received Via: Phone

Admission Details:

Line	From Date	To Date	Requested Days
1	3/18/2020	3/19/2020	1

Diagnosis:

Code	Description
M16.9	OSTEOARTHRITIS OF HIP UNSPECIFIED

Procedures:

Code	Description	Modifier	Date	Requested Units
27130	TOTAL HIP ARTHROPLASTY	--	3/18/2020	1

27130 Details:

Line	From Date	To Date	Requested Units
1	3/18/2020	3/18/2020	1

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Comments: Test note

Overrides: None

Edit Submit

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Preauthorization information will be seen with the Trace number, Authorization # and Status as applicable.


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Prior Approval Details Submitted

Prior Approval entered via EmblemHealth.com on 03/17/2020 at 4:41:40 PM

Your trace number is 36768705. This trace number is provided for your use in corresponding with the HIP Care Management Department in identifying this prior approval request. This Prior Approval does not guarantee payment to the servicing provider/vendor. Payment is contingent on the member's continued eligibility and contractual benefit limits.

Review Type: (I) Inpatient Facility

Category: (AR) Admission Review

Certification: (I) Initial

My Trace #: [REDACTED]

HIP Authorization#: [REDACTED]

Review Status: Approved

Member ID: [REDACTED]

Member Name: [REDACTED]

Member Sex: [REDACTED]

Member DOB: [REDACTED]

Member Plan: [REDACTED]

Member PCP: [REDACTED]

Member PCP Phone: [REDACTED]

Member Eligibility Date: [REDACTED]

Managing Entity: [REDACTED]

Requesting Provider: [REDACTED]

Facility: [REDACTED]

Contact Name: [REDACTED]

Contact Phone: [REDACTED]

Contact Fax: [REDACTED]

Service Type: (2) Surgical

Bed Type: (MD) Medical/Surgical

Admission Date: 03/18/2020

Notify Date: 03/17/2020

Facility Code: (21) Inpatient Hospital

Release Of Info: (Y) Yes, Provider has a Signed Statement

Admission Type: Elective

Received Via: Phone

Requested Days: 1

Approved Days (LOS): 1

Admission Details:

Line	From Date	To Date	Requested Days	Approved Days	Status	Date Modified
1	03/18/2020	03/19/2020	1	1	APPROVED	03/17/2020 4:41:40 PM

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Diagnosis:

Code	Description
M16.9	OSTEOARTHRITIS OF HIP UNSPECIFIED

Procedures:

Code	Description	Modifier	Date	Requested Units	Approved Units
27130	TOTAL HIP ARTHROPLASTY	--	03/18/2020	1	1

27130

Details:

Line	From Date	To Date	Requested Units	Status	Date Modified
1	03/18/2020	03/18/2020	1	APPROVED	03/17/2020 4:40:43 PM

Comments:

^
v

Overrides: None

Entered By:

- [Print Summary Only](#) [Fax Request](#) [Create Another Case](#) [Display QCare Data](#)