NEBRASKA
DEPARTMENT OF INSURANCE

Nebraska Standard Prior Authorization Request Instructions for Health Care Services Including Medical Injectables

Nebraska Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the insurance carrier from whom you are seeking authorization. ***Do not send this form*** *to the Nebraska Department of Insurance, the Nebraska Department of Health and Human Services, or the patient's or subscriber's employer.*

On January 1, 2026, all insurers and providers must accept the Nebraska Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

Intended Use: Use this form to request prior authorization for service(s) by an insurance carrier. Some insurance carriers may offer an **online version of this form** on their website or portal, allowing to complete and submit the request electronically.

Submitters should check the insurance carrier's website to understand all data needed, including clinical data, for that insurance carrier. Failure to do so could delay a decision.

By completing and submitting this form, you are attesting that all information is complete and accurate.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; or 6) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I - Submission: An insurance carrier may have already entered this information on the copy of this form posted on its website.

Section II - General Information: Urgent reviews: Request an urgent review for a patient if waiting seven days for the authorization could (a) seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or (b) subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Section IV - Provider Information

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same".
- If the insurance carrier's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI - Clinical Documentation:

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if required by insurance carrier.

Note: *Some insurance carriers may require more information, which must be reflected on their website, in order to process your request. If additional information is required, it will be outlined on their website. Please check their website before submitting your request.*

Fax Completed form to: MedImpact Healthcare Systems, Inc. at (858) 621-5147.

NEBRASKA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I - SUBMISSION

Insurance Carrier Name:	Phone:	Fax:	Date:

SECTION II - GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment Previous Auth #:		
☐ Continuation of Care	Carrier Name:	Auth #:
(Please attach approved PA details for Continuation of Care in Section VI)		

SECTION III - PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female
Subscriber Name (if different):	Member ID:	Group #:	

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility		**Service Provider**		**Service Facility**	
Name:		Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:	Phone:	Fax:
TIN #:		TIN #:		TIN #:	
Address (Street): City: State: ZIP:		Address (Street): City: State: ZIP:		Address (Street): City: State: ZIP:	
Requesting Provider/Facility Email Address:					
Primary Care Provider Name: (see instructions)				Phone:	Fax:

SECTION V - SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code (CPT, CDT, HCPCS)	Requested Amount	Start Date	End Date	Diagnosis Description (ICD version)	Code

Inpatient: ☐ Yes ☐ No

If Yes: ☐ NICU ☐ Acute Medical ☐ Acute Behavioral Health ☐ Post Acute Medical ☐ Post Acute Behavioral Health ☐ Hospice

Outpatient: ☐ Yes ☐ No

If Yes: ☐ Radiology ☐ Medical ☐ Behavioral Health ☐ Hospice

Home Health: ☐ Yes ☐ No

SECTION VI - CLINICAL DOCUMENTATION (SEE INSTRUCTIONS ON PAGE 1, SECTION VI)

Contact Name:	Phone: