

AUTHORIZATION FORM

Please check Line of Business →	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Healthy Families	<input type="checkbox"/> Network Plus	<input type="checkbox"/> AIM
	<input type="checkbox"/> San Joaquin Health Administrators			

Service requiring Health Plan Approval must be submitted on this form.

Payment is subject to member eligibility and medical necessity determination.

Please confirm eligibility by calling: (209) 942-6320 or IVR (209) 942-6303

Fax this authorization and supporting documents to the Health Plan's UM Department.

UM Department Fax No.: (209) 942-6302

Please fill-in all requested information for timely processing of your request. Completed by:

<input type="checkbox"/> URGENT		<input type="checkbox"/> EMERGENT	
PATIENT		REQUESTING PROVIDER <input type="checkbox"/> PCP <input type="checkbox"/> Specialist	
Name (Last, First) <input type="text"/>		Name <input type="text"/>	
Health Plan Member ID No. <input type="text"/>		Street Address <input type="text"/>	
Date of Birth <input type="text"/> <small>(MM/DD/YY)</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	City, State, Zip <input type="text"/>	
		Phone <input type="text"/>	Fax <input type="text"/>

AUTHORIZE TO

Name / Facility / Hospital <input type="text"/>	Group <input type="text"/>	Pay To <input type="text"/>
Specialty <input type="text"/>	Phone <input type="text"/>	Fax <input type="text"/>
Address <input type="text"/>	City, State, Zip <input type="text"/>	

Non-Contracted
Provider Reason for Requesting a Non-Contracted Provider

Providers outside of the Northern California region, please provide: NPI # Group TIN

REASON FOR AUTHORIZATION REQUEST: Please indicate the quantity () you are requesting for each CPT/HCPCS code. If no quantity indicated the default amount will be "1".

ICD-9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Some ICD-9 codes require a 4th and/or 5th digit. Please document diagnosis completely.</i>						
CPT/HCPCS Code (Quantity)	<input type="text"/> ()	<input type="text"/> ()	<input type="text"/> ()	<input type="text"/> ()	<input type="text"/> ()	<input type="text"/> ()
Modifier Required for DME	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

This procedure will be done in which setting: Office OP IP (if IP, # of Days _____)

Please include copy of clinical notes, findings and indicators to support medical necessity, e.g. explanation of treatment, failure, lab / x-ray results, persistent symptoms despite multiple office visits, etc.

NOTES:

APPOINTMENT DATE <input type="text"/> <small>(MM/DD/YY)</small>	COMMENTS: <input type="text"/>
--	--------------------------------

Date: _____	Requesting Provider Signature: _____
-------------	--------------------------------------