

AUTHORIZATION FORM (AF)

Please check line of business



Medi-Cal Managed Care <input type="checkbox"/>	Healthy Families <input type="checkbox"/>	Healthy Kids <input type="checkbox"/>	Healthy Connections <input type="checkbox"/>
Network+ Plus <input type="checkbox"/>	San Joaquin Health Administrators <input type="checkbox"/>	AIM <input type="checkbox"/>	

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

Payment is subject to member eligibility.

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. URGENT

PATIENT		REQUESTING PROVIDER	
Name		Name	
(Last)	(First)	Street Address	
Health Plan Member ID No.:		City, State, Zip	
Date of Birth: / /	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Phone:	Fax:

AUTHORIZE TO:

Name	Group
Specialty	Phone No. Fax:
Address City, State, Zip	
Non-Contracted Provider <input type="checkbox"/>	
Reason for Requesting a non-contracted provider: _____	

FACILITY/HOSPITAL: _____

REASON FOR AUTHORIZATION REQUEST:

ICD-9: _____	Diagnosis: _____
Procedure Requested: _____	
CPT Code: _____	
This procedure will be done in which setting Office OP IP (If IP # of Days _____)	
Please include copy of chart documentation, findings and indicators to support authorization review, e.g. explanation of treatment, failure, lab/x-ray results, persistent symptoms despite multiple office visits, etc.	
NOTES: _____	

APPOINTMENT DATE: _____ Authorization is valid for 90 days from appointment date or signature.	Comments:
Date:	Requesting Provider Signature