Health Plan of San Joaquin

AUTHORIZATION FORM

Please check Line of Business	☐ Medi-Cal	☐ Inpatient _____ Days ☐ Outpatient ☐ Office Visit

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.

Inpatient Fax (209) 762-4702 San Joaquin

Inpatient Fax (209) 762-4703 Stanislaus

Outpatient Fax (209) 942-6302

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

☐ ROUTINE ☐ URGENT	☐ PCP ☐ Specialist	
PATIENT	REQUESTING PROVIDER	**NPI** **TIN**
Name *(Last, First)*	Name	
Health Plan Member ID No.	Street Address	
Date of Birth *(MM/DD/YY)* / Sex: ☐ Male ☐ Female	City, State, Zip	
Appointment Date	Phone / Fax	

AUTHORIZE TO (Service Provider)

Provider/ Facility	Group / Pay To	
Specialty	Phone	Fax
Address	City, State, Zip	

REQUIRED INFORMATION FOR SERVICE PROVIDERS:	Provider NPI #	**Tax ID**:	**Facility/ Group NPI**

Comments:

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

ICD-10						

Some ICD-10 codes are reported to their highest number of characters available (3, 4, 5, 6 or 7). *Please document diagnosis completely.*

CPT/HCPCS Code / Quantity					
Modifier Required for DME					

Date: _____ Requesting Provider Signature: _____