

Authorizations are based on covered benefits and medical necessity. Authorizations are contingent upon member's eligibility and are not a guarantee of payment. The provider is responsible for verifying the member's eligibility on the date of service. **Important: Appropriate clinical documentation is required to support your request.**

Member Information		Type of Request (please check <u>only one</u>)	
Last Name:		<input type="checkbox"/> Routine	Medi-Cal: 5 business days Cal MediConnect: <u>14 calendar days</u>
First Name:			
Member ID:		<input type="checkbox"/> Urgent	<u>72 hours</u> Inappropriate use will be monitored
DOB:			
Line of Business:	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Cal MediConnect	<input type="checkbox"/> Retro	<u>30 calendar days</u> <i>Only granted for member eligibility on DOS</i> Date of Service: _____

Requesting Provider					
Name:		Specialty/Dept:			
Address:					
City:		State:		Zip:	
Office Contact:		Phone:		Fax:	
NPI #:		TIN #:			

Rendering Provider/Facility					
Name:		Specialty/Dept:			
Address:					
City:		State:		Zip:	
Office Contact:		Phone:		Fax:	
NPI #:		TIN #:			
<input type="checkbox"/> Non-Contracted. Reason for out of network request:					

Service Requested:	<input type="checkbox"/> Inpatient (Elective)	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Home Health
	<input type="checkbox"/> Provider Office	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Radiology
ICD-10 Code(s)			

No.	CPT/HCPCS	Description	Mod	Quantity	
				Unit(s)	Visit(s)
1.					
2.					
3.					
4.					
5.					

Please attach separate page if you have additional line items.

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