

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:		☐ Routine <u>7 calendar days</u>
First Name:		
Member ID:		☐ Urgent <u>72 hours</u> <i>Inappropriate use will be monitored</i>
DOB:		
MRN:		☐ Retro <u>30 calendar days</u> <i>Only granted for member eligibility on DOS</i> Date of Service: _____
Line of Business:	☐ Medi-Cal ☐ DualConnect (HMO D-SNP)	☐ Continuity of Care Request

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 #:		
☐ Non-Contracted. Reason for out of network request:					

Service Requested:	☐ Inpatient (Elective)	☐ Skilled Nursing Facility	☐ Home Health
	☐ Provider Office	☐ Outpatient	☐ DME ☐ 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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