Santa Clara Family Health Plan™

Prior Authorization Request Form

Medical Services | Utilization Management

Phone: 1-408-874-1821 Fax: 1-408-874-1957

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 only one)**	
Last Name:		☐ **Routine**	7 calendar days
First Name:			
Member ID:		☐ **Urgent**	72 hours ***Inappropriate use will be monitored***
DOB:			
MRN:		☐ **Retro**	30 calendar days *Only granted for member eligibility on DOS* **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.					