

Fax: 510-662-3492 Provider Services: 800-615-0261

Prior Authorization Request Form

Please check type of request: Routine (Non-urgent services)		☐ Expedited (Medicare only—Care required within 72 hours)		
☐ Urgent/Concurrent (Care requi	red within 24 hours)	☐ Submission of additional clinic	cal information	
Patient Name:	DOB:	Daytime Phone:		
Health Plan:	Health Plan ID	#:		
Address:	City:	State:	Zip:	
Facility/Pr	ovider/Service Info	rmation:		
Referring Provider:	□ PCP □ S	SPEC Phone:		
Provider Signature:	Date:	Fax:		
☐ Office ☐ Outpatient ☐ Inpatient Admit ☐ Diagno		Home Health ☐ Injectables	□ Other	
Name:	First Name:	Last Name:		
Address:	Phone:	Fax:		
Requested Service(s):		REQUIRED:		
		ICD9 Code(s):		
		CPT Codes(s)		
Diagnosis/Clinical Problem:				
Clinical History/Date of Onset:				
Prior Treatment:				
Relevant Diagnostic Testing:				
Form Submitted by:	Date	Phone:		

THIS AUTHORIZATION IS BASED ON ELIGIBILITY AT TIME THE SERVICES ARE RENDERED.

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Authorization Request Form Jan 2013