



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 required within 24 hours)  Submission of additional clinical information

Patient Name:		DOB:	Daytime Phone:	
Health Plan:		Health Plan ID#:		
Address:		City:	State:	Zip:
<b>Facility/Provider/Service Information:</b>				
Referring Provider:		<input type="checkbox"/> PCP <input type="checkbox"/> SPEC	Phone:	
Provider Signature:		Date:	Fax:	
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Admit <input type="checkbox"/> Diagnostics <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Injectables <input type="checkbox"/> Other _____				
<b>Requested Provider/Facility:</b>			<b>Requested Physician/Specialist:</b>	
Name:		First Name:	Last Name:	
Address:		Phone:	Fax:	
Requested Service(s):		<b>REQUIRED:</b>		
		ICD10 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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