Higher Level of Care - AUTHORIZATION FAX REQUEST FORM

L.A. Care HEALTH PLAN

Pre-Service Fax: 213.438.5761 Phone: 877.431.2273			Inpatient Fax: 213.438.2204 Phone: 877.431.2273
☐ COMPLEX CANCER	☐ COMPLEX GASTRO-INTESTINAL	☐ COMPLEX GYN	☐ DISCHARGE ORDERS
☐ COMPLEX CARDIAC	☐ COMPLEX ENDOCRINOLOGY	☐ COMPLEX UROLOGY	☐ HLOC TRANSFERS
☐ COMPLEX RESPIRATORY	☐ COMPLEX ORTHOPEDICS	☐ COMPLEX NEUROLOGY	

Requested Tertiary and Quaternary Provider / Facility (select one)**:**

☐ **UCLA Health** (Medical Center and Satellite locations) ☐ **UCLA Medical Group** ☐ **City of Hope** ☐ **City of Hope Medical Foundation**
☐ **No Preference** ☐ **Other (fill out info in Servicing Provider/Facility section)**

Select the TQ Medical Group/Facility your Participating Physician Group (PPG) holds a direct contract with:

☐ **UCLA Health** (Medical Center and Satellite locations) ☐ **UCLA Medical Group** ☐ **City of Hope** ☐ **City of Hope Medical Foundation**
☐ **Other (fill out info in Servicing Provider section)**

Complete *BOLDED required fields below to avoid delays in processing

If this request is for an extension or modification of an existing authorization, please provide the original authorization number here: _____

***Request Date:**	***Request Type:** ☐ **Routine** ☐ **Urgent** ☐ **Post Service** ☐ **Inpatient**		
***Member ID:**	***Date of Birth:**		
***Member Name:**			
***Preferred Written Language:**	***PCP Name:**		
***Requesting Provider/Facility:**		***Specialty:**	
***Phone Number:**	***Fax Number:**	***NPI:**	
Address:		City:	Zip:
***Servicing Provider/Facility:**		***Specialty:**	
***Phone Number:**	***Fax Number:**	***NPI:**	
***Address:**		***City:**	***Zip:**

***List ICD-10 Codes below:**

***CPT / HCPCS Codes / Descriptions for service(s) Requested**

Attach all clinical indications for TQ level of care (incl. pertinent past treatments, physical findings and all relevant medical records, test results, etc.):

☐ **Redirect Attempt 1** (Facility Name): _____

☐ **Redirect Attempt 2** (Facility Name): _____

☐ **Continuity of Care** (COC) (Provider name/specialty type): _____ **Date of last visit**: _____

Provider Name: (Print)	**Provider Signature:**	**Date:**

If the physician would like to discuss this case with the Medical Director or would like a copy of the criteria used to make this decision, please call the number listed on the fax cover sheet of your decision letter.

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE

Do not schedule non-emergent services until authorization is obtained