

AUTHORIZATION REQUEST FORM



Please fax completed form to appropriate L.A. Care UM Department fax number listed below:

Prior Authorization: 213.438.5777
 Urgent: 213.438.6100
 Inpatient: 1.877.314.4957
 Delegate Support Team (DST): 213.438.5761
Transplant: 213.438.5071
 Medicare: 213.438.5077
 L.A. Care Direct Network: 213.438.5680

*If the treating physician would like to discuss this case with the physician or health care professional reviewer or would like to obtain a copy of the criteria used to make this decision, please call **1.877.431.2273**.*

Request Information			
Request Date:		Request Status:	
Request Type: (check one) <input type="checkbox"/> Urgent <input type="checkbox"/> Routine <input type="checkbox"/> Prior <input type="checkbox"/> Concurrent <input type="checkbox"/> Post Service			
Patient Information			
Member Name:		Date of Birth:	
Preferred Written Language:		Member ID:	
Address:	City:	Zip:	Phone:
PCP:		PPG:	
Line of Business (check one): <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Cal MediConnect <input type="checkbox"/> L.A. Care Covered <input type="checkbox"/> PASC-SEIU			
Request - Service Type Requested			
<input type="checkbox"/> Acute Hospital, Community	<input type="checkbox"/> DME Expected Duration:	<input type="checkbox"/> Palliative Care (not hospice)	
<input type="checkbox"/> Acute Hospital, Tertiary	<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Prosthetic/Orthotics	
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Home Health	<input type="checkbox"/> Transgender Health	
<input type="checkbox"/> CBAS - Initial request	<input type="checkbox"/> Hospice	<input type="checkbox"/> Transplant Evaluation	
<input type="checkbox"/> CBAS - Renewal	<input type="checkbox"/> Long Term Care – Initial Request	<input type="checkbox"/> Other (Specify):	
<input type="checkbox"/> Clinical Trial (not investigational)	<input type="checkbox"/> Long Term Care – Renewal		
<input type="checkbox"/> Diagnostic Procedure/Radiology	<input type="checkbox"/> Nursing Facility, short term skilled care		
Provider Submitting Request			
Requesting Provider Name:		Speciality:	
Phone Number:	Fax Number:	NPI:	
Address:	City:	Zip:	
Provider Performing/Providing Service			
Requested Provider Name:		Speciality:	
Phone Number:	Fax Number:	NPI:	
Address:	City:	Zip:	
Diagnosis/Procedure Information			
Clinical Indications for request (include pertinent past medical treatment, physical findings and attach all relevant medical records, test results, etc.):			
ICD-10 Code(s)/Description:			
CPT Code(s)/Description:			
HCPCS Code(s)/Description (If available):			
Is the service being requested out of network? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, please provide reason for using an out of network facility:			
Provider Name (Print First and Last Name):		Provider Signature:	Date:

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE
Do not schedule non-emergent requested service until authorization is obtained.