DIFFICULT PLACEMENT (DPT) AUTHORIZATION FAX REQUEST FORM

L.A. Care HEALTH PLAN

DPT Fax: 213-438-5095 DPT Phone: 877-431-2273
☐ Discharge order (Please include Hospital name, admit date and discharge date)
☐ Continued stay

Complete *BOLDED required fields below to avoid delays in processing

***Request Date:**			
***Member ID:**	***Date of Birth:**		
***Member Name:**			
***Preferred Written Language:**	***PCP Name:**		
***Requesting Provider/Facility:**		***Specialty:**	
***Phone Number:**	***Fax Number:**	***NPI:**	
Address:		City:	Zip:
***Name of Requested Facility:**		***Contact Person:**	
***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 requested facility/level of care (request must include most current wound care, PT/OT/ST/RT notes and discharge summary etc.):			
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