



Facility NPI									
Contact First Name									
Contact Phone Number									
Return Fax Number									

Member ID									
Member Last Name									
Member DOB					MM/DD/YYYY				
LAC Auth # (if known)									

Hospital Priority & Type of Clinical Service Requested – For Hospital Use Only!
To ensure prompt and efficient processing, please check appropriate boxes and clearly enter data in each block
Do not submit requests for approval of Observation Level of Care – Authorization is not required

Initial Service From Date (MM/DD/YYYY)					Primary ICD-10 Code				
		/		/				.	

<u>ANY Facility Admission</u> <i>Documentation REQUIRED</i>		<u>Concurrent Review</u> <i>Documentation REQUIRED</i>	
<input type="checkbox"/>	<u>Routine Request</u>	<input type="checkbox"/>	<u>Extended Stay Requested</u> <i>All Clinical Records + Detailed Data Supporting Continued Stay</i>
<input type="checkbox"/>	<u>Urgent / Expedited Request</u>	<input type="checkbox"/>	<u>Higher Level of Care (Concurrent Review)</u> <i>All Clinical Records + Detailed Data Supporting Higher Level of Care Continued Stay</i>
<input type="checkbox"/>	<u>Initial Review</u> <i>Facility Face Sheet & All Clinical Records / Supporting Data</i>	<input type="checkbox"/>	<u>Transfer Request</u> <i>All Clinical Records + Detailed Data Supporting Placement Request</i>
<input type="checkbox"/>	<u>Higher Level of Care (Initial)</u> <i>Facility Face Sheet & All Clinical Records + Detailed Data Supporting Higher Level of Care</i>	<input type="checkbox"/>	<u>Difficult Placement Assistance</u> <i>All Clinical Records + Detailed Placement Attempts</i>

- OR -

Discharge Planning Notification									
<input type="checkbox"/>	Expected Discharge Date			/			/		
<input type="checkbox"/>	Actual Discharge Date			/			/		
REQUIRED Attachment if Discharging Member Please Select One & Include Relative Documentation									
<input type="checkbox"/>	Discharge Orders	<input type="checkbox"/>	Discharge Plan						

Fax to LA Care Health Plan: (877) 314-4957

PL1304 0522

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