Barcode Here





## **Service Authorization Request**

For L.A. Care Medi-Cal and L.A. Care Medicare Plus (HMO D-SNP) Members Only Fax to 1-213-536-0638 Email: mealsasmedicine@lacare.org

Please select request type. Signature required on page 2.																															
Routine Request (use meal program option 1 below)  Urgent Request (72-hour processing; use meal program option 1.)																															
Post-Discharge (72-hour processing; use option 1. For D-SNP members not meeting criteria under option 1, please use option 2.)																															
Member information																															
Line of Business: Medi-Cal L.A. Care Medicare Plus (HMO D-SNP)																															
Member Number								1	Member DO			В			1	1			_	Me	embe	r Ph	one	1							
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First N	lame	<u> </u>					1			1	ı		1		7	Las	st Na	me		1		1	1			1					
Member's Address & Language preference are on file with L.A. Care and will be used to process this request. Any updates must be completed by contacting Customer Service 24 hours a day-7 days a week at 1-888-839-9909 for Medi-Cal or at 1-833-522-3767 for D-SNP members.																															
Caregiver Contact information & Official Designation Title																															
First N	lame													Las	st Nar	me															
Phone	Nur	nber												Titl	le / R	elatio	onshi	ip													
Referring Entity																															
Please select entity type. Referring entities with an asterisk (*) must provide their NPI below.  PCP / Specialist*  Skilled Nursing Facility*  Community Supports Provider*  Community Based Adult Services																															
Hospital*  ECM Provider*  Community Supports Provider*  Community Supports Provider*  Community Based Organization  Member's PPG/MSO																															
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Internal L.A. Care Entity:																															
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Utilization Management Managed Long Term Services & Supports (MLTSS) Pharmacy																															
	ther	: [																													
Referr	Referring Provider or Member's PCP NPI* Phone Fax																														
	Ť									]																					
Referring Entity Name																															
Addre	SS																														
City Zip									LA	LAC Provider ID																					
Email																															
Please	use a	n In-N	letwo	rk Pr	ovide	r NPI	& Pro	vider	ID if a	ıvaila	ble to	comp	olete t	his fo	rm. Fi	nd th	ese at	: http	s://wI	ww.la	care.c	org/fii	nd-do	ctor-c	or-ho	spital					

Checking this box attests that Program Eligibility for Extra Benefits & Services have been discussed and have received "Member Consent" to collect necessary clinic

al & supportive documentation from qualified clinical practitioner with direct knowledge and treatment responsibility.

Barcode Here





## **Service Authorization Request**

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Please complete the required fields for one of the two available program options below. Signature required.														
Option 1: Community Supports (2 meals per day for 12 weeks)														
Medi-Cal and L.A. Care Medicare Plus (HMO D-SNP) members meeting diagnosis criteria below. Routine, urgent or post-discharge.														
Criteria*: Please check all that apply. For a member to be eligible for the MTM Program, they must have at least one of the listed chronic conditions. Please select chronic condition(s) AND confirm member doesn't have any of the listed exclusion criteria														
Chronic Condition Criteria*	Exclusion Criteria*													
Member must have at least one of the chronic conditions listed below. Please select all that apply.	Member <u>must not</u> have any of the following exclusions. Please check the box below to confirm.													
Congestive Heart Failure (Age 40 or above)	<ul> <li>Gestational Diabetes, Dependence on Renal Dialysis, End-Stage Renal Disease; OR</li> </ul>													
Chronic Kidney Disease (Age 18 or above)  Stage 3 (eGFR 30-59)  Stage 4 (eGFR 15-29)	<ul> <li>Member is currently in another MTM program; OR</li> <li>Member does not have access to cold food storage; OR</li> <li>Member is unable to receive home-delivered meals; OR</li> </ul>													
Diabetes with an A1c ≥ 9 (Age 18 or above)	<ul> <li>Member is in a Hospice Facility or Skilled Nursing Facility; OR</li> <li>Member is incarcerated</li> </ul>													
Please attach any clinical notes or other documentation in support of this referral (if available).	Check this box to confirm that the member does not have any of the exclusion criteria listed above.													
Diet Requested* (Please check only one) Note: Must	be consistent with what health care provider has prescribed													
Heart Healthy / Lower Sodium Diet Kidney / Renal Friendly Diet Diabetes Friendly Diet														
Option 2: Post-Discharge Benefit (2 meals per day for 2 weeks)														
L.A. Care Medicare Plus (HMO D-SNP) members only. Post-discharge only. Consider Option 1 for longer benefit if member meets criteria.														
Post-Discharge Diagnosis Please list the post-discharge diagnosis and/or primary chronic conditions. Not bound to criteria in Community Supports Meal Option 1 above.														
Diagnosis / Health Condition 1	ICD-10 Code													
Health Condition 2	ICD-10 Code													
Health Condition 3	ICD-10 Code													
Please submit any clinical notes or other documentation in support of thi	s referral (if available).													
Diet Requested* (Please check only one) Note: Must be consistent with what health care provider has prescribed.														
Diabetes Friendly Kidney / Renal Friendly Heart Healthy / Lower Sodium Cancer Pureed														
General Wellness														
Additional Comments / Summary (if any)														
Referred by Signature	Date Signed M M / D D / Y Y													