☐ **Prior Authorization Fax Request Form ~OR~**

☐ **Referral Form (*L.A. Care Direct Network Only*)**

If you are a PCP or Specialist requesting a referral to an In-Network Provider, mark the box above for *Referral Form* there is NO PRIOR AUTH REQUIRED for this referral.
Fax a copy of this Referral and your Clinical notes to the In-Network Servicing Provider to notify them of your Referral and direct your patient to call for an appointment.

☐ **Referral Form for Standing Referrals (*L.A. Care Direct Network Only*)**

Standing referrals may be needed for members with a condition that requires specialized care over an extended amount of time. If you are a PCP or Specialist requesting a standing referral to an In-Network Provider, mark the box above for *Referral Form for Standing Referrals*. NO PRIOR AUTH REQUIRED for these services.
FAX this referral along with clinical notes to the In-Network Servicing Provider AND to L.A. Care at 213-438-5777

Outpatient and Elective Services **Routine / Post Service Fax: 213.438.5777 / Urgent Fax: 213.438.6100**				**Behavioral Health Fax: 213-438-5054**
☐ Acupuncture ☐ Chiropractic ☐ Clinical Trials ☐ DME/Supplies ☐ Home Health	☐ Hospice ☐ IP Surgery ☐ Laboratory / Pathology ☐ OP Surgery ☐ Palliative Care	☐ Pharmacy ☐ Private Duty Nursing ☐ Prosthetics ☐ PT / OT / ST ☐ Radiology	☐ Specialty Referral ☐ Transgender Services ☐ Transplant Eval to Surgery	☐ BH Therapy / ASD
				CBAS Fax: 213-438-5739
				☐ Community Based Adult Services
LTC / SNF / ICF Fax: 213-438-4877				**Transportation Fax: 213-438-2201**
PASRR results required for: **PASRR results not required for:**	☐ Long Term Care ☐ ICF/DD	☐ Subacute Care – Adults ☐ ICF/DD-H	☐ Subacute Care – Pediatrics ☐ ICF/DD-N	☐ Non- Emergency Medical Transport

Not sure whether service requires prior authorization? Use our code look-up tool https://www.lacare.org/providers/provider-resources/prior-authorization-search
Any questions? Call the L.A. Care UM Call Center at 877.431.2273 ***Complete *BOLDED required fields below to avoid delays in processing***

Member Information	
***Member ID:**	***Date of Birth:** / /
***Member Name:**	
Requesting Provider Information	
To find an in-network Provider please visit http://www.lacare.org/find-doctor-or-hospital	
***Request Date:** / /	***Request Type:** ☐ Routine ☐ Urgent ☐ Post Service
***Requesting Provider:**	***NPI:**
***Phone Number:**	***Fax Number:**
***Address:**	***City:** ***Zip:**
***Starting Service Date:** / /	***Ending Service Date:** / /
Servicing Provider Information	
***Servicing Provider:**	***NPI:**
***Phone Number:**	***Fax Number:** ***Specialty:**
***Address:**	***City:** ***Zip:**
***Place of Service:** ☐ Office ☐ Home ☐ Inpatient ☐ Outpatient ☐ Other:	
Facility Provider Information (if applicable)	
***Servicing Facility:**	***NPI:**
***Phone Number:**	***Fax Number:**
***Address:**	***City:** ***Zip:**
***List ICD-10 Codes:**	
***CPT / HCPCS Codes for requested service(s) including Quantity:** Describe clinical Indications & include pertinent past medical treatment, physical findings and attach all relevant medical records.	
Is the service being requested Out of Network? ☐ *No* ☐ *Yes* If yes, please provide reason for Out of Network facility/provider:	
Print Requesting Provider Name:	**Provider Signature:** **Date:**

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AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE – DO NOT SCHEDULE NON-EMERGENT SERVICES UNTIL AUTHORIZATION IS OBTAINED