PACIFIC HEALTH ALLIANCE PRE-AUTHORIZATION FORM

IF MEDICAL RECORDS ARE NOT RECEIVED, IT WILL NOT BE REVIEWED. PLEASE COMPLETE THE FORM IN ITS ENTIRETY. ALL TAX I.D./ CPT CODES MUST BE COMPLETED.

#11

PHONE: (855) 754-7271 FAX: (650) 425-9468

Date of Request: _____

☐ **Urgent (24 hours) Use only when following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.**

Member Information

Health & Welfare Plan Name: _____ ***Member's Plan Network:*** _____

Patient Name: _____ ***DOB:*** _____ ***MID#*** _____

(Attach a copy of medical insurance card)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone# of Subscriber: _____ ***Medicare Primary*: ☐ Yes ☐ No *Other Insurance*: ☐ Yes ☐ No**

Ordering Physician Information

Ordering Physician: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Tax ID # _____ **Requesting Physician Signature:** _____ **Date:** _____

YOUR NAME: _____ **CONTACT PHONE #:** ( ) _____ ***Is your provider contracted w/member's plan*: YES ☐ NO ☐**

***Diagnosis :** _____ ***ICD9:** _____

***Service Being Rendered:** _____ ***Quantity of visits if applicable:** _____

***CPT/HCPC Codes :** _____ _____ _____ _____ _____ _____

Authorization Request

SPECIALIST/ FACILITY: _____ **TAX ID#:**_____

***Is this rendering provider contracting with member's plan*: YES ☐ NO ☐**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **FAX:** _____

Expected Date of Service _____ **Is this a retro authorization? If so please indicate date/range here:** _____

☐ **Office** ☐ **Inpatient Services** ☐ **Outpatient Services** ☐ **23 Hour Short Stay**

PHA USE ONLY – DO NOT WRITE BELOW THIS LINE!!!!!!!

Approved ☐ # of Visits: _____ ☐ **Interqual Guidelines Met #** _____

***Authorization Number*:** _____ **Valid From:** _____**to** _____**Expirations Date**

Denied ☐ Denial Reason: _____

Other ☐ _____

_____

_____ _____ _____

Medical Director Signature **Case Manager/ Care Counselor Signature** **Date**

******Authorization is subject to eligibility & benefits on date of service.******

To ensure proper payment for services rendered, please verify eligibility on date of service. If member is determined to be ineligible on date of service, he/she may be responsible for payment of these services. Please contact the number listed on the patient card to verify eligibility.

Please send all claims to the address listed on the patient ID card