



Fax: 510-662-3492
 Provider Services: 800-615-0261

Prior Authorization Request Form

Please check type of request: Routine (Non-urgent services) Expedited (Medicare only—Care required within 72 hours)
 Urgent/Concurrent (Care required within 24 hours) Submission of additional clinical information

Patient Name:	DOB:	Daytime Phone:
Health Plan:	Health Plan ID#:	
Address:	City:	State: Zip:
Facility/Provider/Service Information:		
Referring Provider:	<input type="checkbox"/> PCP <input type="checkbox"/> SPEC	Phone:
Provider Signature:	Date:	Fax:
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Admit <input type="checkbox"/> Diagnostics <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Injectables <input type="checkbox"/> Other _____		
Requested Provider/Facility:		Requested Physician/Specialist:
Name:	First Name:	Last Name:
Address:	Phone:	Fax:
Requested Service(s):	REQUIRED: ICD9 Code(s): CPT Codes(s)	
Diagnosis/Clinical Problem: Clinical History/Date of Onset: Prior Treatment: Relevant Diagnostic Testing:		

Form Submitted by: _____ Date _____ Phone: _____

THIS AUTHORIZATION IS BASED ON ELIGIBILITY AT TIME THE SERVICES ARE RENDERED.

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