



## SERVICE AUTHORIZATION FORM

FORM MUST BE FILLED OUT COMPLETELY

Please select the following:

Today's Date: \_\_\_\_\_

RETROSPECTIVE (DOS): \_\_\_\_\_

ROUTINE (NON-URGENT)

URGENT (EXPEDITED) Urgently needed care means services that are required in order to prevent serious deterioration of a member's health that results from an unforeseen illness or injury.

### HEALTH PLAN (Please check):

Aetna	Blue Shield Promise Health Plan	Cigna	United Healthcare
Alignment	Brand New Day	Healthnet	United Healthcare Medicare
Anthem CA Care	CareMore Anthem Cal Mediconnect	Healthnet Medicare	Vitality
Anthem BC Medi-Cal	CareMore Anthem BC	SCFHP Medi-Cal	
Blue Shield	CareMore SCAN	SCFHP Healthy Kids	

### PATIENT INFORMATION

MEMBER ID#	DATE OF BIRTH:
PATIENT NAME:	PATIENT ADDRESS:
PATIENT PHONE#:	
PCP:	PCP PHONE#:

### REQUESTING PROVIDER INFORMATION

PROVIDER NAME:	PHONE#:
OFFICE CONTACT NAME:	FAX#:

### REFERRING TO PROVIDER INFORMATION

*CLINICAL DOCUMENTATION MUST BE SUBMITTED WHEN REQUESTING SERVICES*

PROVIDER NAME: (IF NON-CONTRACTED, PROVIDE NPI# & TAX ID#)				
PHONE#:				
FAX#:				
OFFICE CONTACT NAME:				
FACILITY:				
<b>PLEASE CHECK ONE SERVICE:</b>	<b>ICD-10</b>	<b>CPT / HCPCS</b>	<b>UNITS</b>	<b>QTY</b>
<input type="checkbox"/> CONSULTATION / FOLLOW UP				
<input type="checkbox"/> DME				
<input type="checkbox"/> HOME HEALTH				
<input type="checkbox"/> INPATIENT PROCEDURE				
<input type="checkbox"/> OUTPATIENT PROCEDURE				
<input type="checkbox"/> OB CARE EDD _____				
<input type="checkbox"/> SKILLED NURSING FACILITY				

<b>CLINICAL INDICATION:</b>

REQUESTING PROVIDER SIGNATURE: \_\_\_\_\_

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