PACIFIC HEALTH ALLIANCE

PRE-AUTHORIZATION FORM

## IF MEDICAL RECORDS ARE NOT RECEIVED WITH THIS FORM IT WILL NOT BE REVIEWED. PLEASE COMPLETE THE FORM IN ITS ENTIRETY. TAX ID AND CPT CODES MUST BE INCLUDED.

Member Name:       DOB:       MID#         Address:       City:       State:       Zip:         Member Phone:       Medicare Primary:       Yes       No       Other Insurance:       Yes       No         Requesting Provider Information       Requesting Provider Information       Fax:       Zip:	Date of Request: PHONE: (855) 754-727	71 FAX: (650) 425-9468	3		
Health & Welfare Plan Name:	Urgent (24 hours) Check this box only when following the standard tin	ne frame could seriously je	opardize the member's lif	e or health.	
Member Name:       DOB:       MID#         Address:       City:       State:       Zip:         Member Phone:       Medicare Primary:       Ves       No       Other Insurance:       Ves       No         Requesting Provider:       Phone:       Fax:       Zip:	Member	Information			
Member Phone:	Health & Welfare Plan Name:	Member's Plan Netwo	rk:		
Requesting Provider Information         Requesting Provider Information         Address:	Member Name:	_ DOB:	<i>MID</i> #	MID#	
Requesting Provider Information         Requesting Provider Information         Address:	Address:	_ City:	State:	Zip:	
Requesting Provider:       Phone:       Fax:         Address:       City:       State:       Zip:         TAX ID #:       NPI:       Requesting Provider Signature:       Date:	Member Phone: Media	care Primary: 🔲 Yes 🔲	No Other Insurance:	Yes No	
Address:	Requesting F	Provider Information			
TAX ID #:	Requesting Provider:	Phone:	Fax:		
YOUR NAME:       CONTACT PHONE:       Is this provider contracted with the member's plan?         Diagnosis:       Yes       No         Diagnosis:       CDL10	Address: City	y:	State:	Zip:	
TOR NAME:       CONTACT PHONE:       Image: Contact Phone: <td< td=""><td>TAX ID #: NPI: Requesting</td><td>Provider Signature:</td><td></td><td> Date:</td></td<>	TAX ID #: NPI: Requesting	Provider Signature:		Date:	
Requested Service:       Quantity of visits, if applicable:         CPT/HCPC Codes:	YOUR NAME: CONTACT PHONE:	Is t	· _		
CPT/HCPC Codes:	Diagnosis:	ICD.10			
Facility Information         FACILITY/SPECIALIST:	Requested Service:		_ Quantity of visits, if app	blicable:	
FACILITY/SPECIALIST:       TAX ID #:       NPI:         Is the facility/specialist contracted with member's plan?       Yes       No         Address:       City:       State:       zip:         Phone:       Fax:       City:       State:       zip:         Phone:       Is this a retro authorization? If so, please indicate date/range:       State:       State:       Zip:         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       Expiration Date         Denied       Denial Reason:       Valid From:       to	CPT/HCPC Codes:				
Is the facility/specialist contracted with member's plan? Yes No  Address: City: State: Zip: Phone: Fax: Fax: Fax: Expected Date of Service: Is this a retro authorization? If so, please indicate date/range: Expected Date of Service: Is this a retro authorization? If so, please indicate date/range:  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: toExpiration Date Denial Reason:	Facility II	nformation			
Is the facility/specialist contracted with member's plan? Yes No  Address: City: State: Zip: Phone: Fax: Fax: Fax: Expected Date of Service: Is this a retro authorization? If so, please indicate date/range: Expected Date of Service: Is this a retro authorization? If so, please indicate date/range:  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: toExpiration Date Denial Reason:	FACILITY/SPECIALIST: TAX ID #	#:	NPI:		
Phone: Fax:   Expected Date of Service:   Inpatient Services   Inpatient Services   Office   Inpatient Services   Outpatient Services   PHA USE ONLY – DO NOT WRITE BELOW THIS LINE!!!!!!   Approved   # of Visits:   Authorization Number:   Valid From:   to Expiration Date					
Phone: Fax:   Expected Date of Service:   Inpatient Services   Inpatient Services   Office   Inpatient Services   Outpatient Services   PHA USE ONLY – DO NOT WRITE BELOW THIS LINE!!!!!!   Approved   # of Visits:   Authorization Number:   Valid From:   to Expiration Date	Address:	City:	State:	Zin-	
Expected Date of Service:     Inpatient Services     Outpatient Services     Inpatient Services     Outpatient Services     23 Hour Short Stay     PHA USE ONLY – DO NOT WRITE BELOW THIS LINE!!!!!!     Approved   # of Visits:				 Σιρ	
Approved       # of Visits:       Interqual Guidelines Met #         Authorization Number:       Valid From:       to         Denied       Denial Reason:       Valid From:	Expected Date of Service: Is this a retro authorizat	ion? If so, please indicate	date/range:		
Approved    # of Visits:    Interqual Guidelines Met #      Authorization Number:    Valid From:    to      Denied    Denial Reason:    Expiration Date	Office Inpatient Services	Outpatient Services	🔲 23 Hou	r Short Stay	
Authorization Number:       Valid From:       to       Expiration Date         Denied       Denial Reason:	PHA USE ONLY – DO NOT V	WRITE BELOW TH	IS LINE!!!!!!		
Denied Denial Reason:	Approved 🔲 # of Visits: [	Interqual Guidelines M	et #		
	Authorization Number:	Valid From:	to	Expiration Date	
Other	Denied Denial Reason:				
	Other				
Medical Director Signature       Case Manager/Care Counselor Signature       Date         ***Authorization is subject to eligibility & benefits on date of service. There is no guarantee of payment***					

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, they may be responsible for payment of these services. Please contact the number listed on the patient card to verify eligibility.