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