Authorization Request

Instructions

Prior authorizations are not required for referrals to network specialists for initial consultations and follow-up appointments. Prior authorizations are required for all procedures and medical services listed in the table below. Use a Referral Request form to make a referral for initial consultations and all follow-up appointments.

Authorization Request Instructions

Prior authorizations are required for all procedures and medical services listed in the table below, and for any specialist visits beyond initial and follow-up appointments. **Providers and facilities must be in network.** Complete this form and fax it to Utilization Management at (888) 238-7463. Routine authorization requests are processed within 14 days. Please call (800) 474-1434 for authorization status. Claim(s) will be paid if a prior authorization has been granted. Patient eligibility should be verified at time of service, see below.

Eligibility Verification

For **PHP (HMO SNP)** (Medicare Advantage Part D plan) and **PHC California** (Medi-Cal HMO plan) eligibility verification, please call (800) 263-0067.

Specialty Services Requiring Prior Authorization

- All inpatient care (acute, subacute, SNF, and long-term)
- Home health care, including skilled nursing, rehab, and home infusion
- Imaging studies (excluding mammography, x-ray and ultrasounds or single/flat view studies) and nuclear medicine
- Interventional radiology
- Outpatient surgery, rehabilitation including PT/OT/ST and chemotherapy
- Photo and radiation therapy
- Wound care
- Injectables (Part B) administered in physician's office other than immunizations administered by a PCP
- Durable medical equipment (DME)
- Dialysis in service area
- Colonoscopy and endoscopy
- EMG, nerve conduction studies
- Hearing aids
- Orthotics and prosthetics
- Cardiac testing (excluding EKG) and catheterization

Date of Request: ______________________ Check if Urgent ☐

Patient Information

Patient Name ______________________

Select Plan Option:
☐ PHP (Medicare)
☐ PHC California (Medi-Cal)

Member ID Number ______________________ Birth Date ______________________

Primary Care Provider Name ______________ Contact ______________ Phone ______________ Fax ______________

Referring Provider Information

Primary Care Provider Name ______________ Contact ______________ Phone ______________ Fax ______________

Indication for Referral

Diagnosis(es)/Code(s) ______________________

CPT Code(s) ______________________

List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data ______________________

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Requested Consultation or Service ______________________

Requested (Refer to) Provider Information

Requested Provider/Facility Name ______________ Phone ______________ Fax ______________

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