Specialty Referral & Preservice Authorization Form

Instructions

Specialty Referrals: All specialty consultations can be referred directly to the specialist. All visits and clinically indicated non-invasive procedures can be performed ***without a prior authorization number.*** Your patients must see ***in-network*** providers/physicians and utilize contracted facilities shown on your current provider roster. Please give this direct referral form to your patient to make the appointment and ask that he or she bring this form to the requested specialist/facility. **Direct Specialty Referrals do not need to be sent to the Plan.** Please have the member call Member Services for assistance with assisting with locating a provider. Providers can also be located on our website positivehealthcare.net

Preservice Authorizations. Prior authorization is required for all procedures and medical services listed in the table below. Approved initial authorizations are valid up to 90 days. After that time, a new request will need to be submitted along with updated supporting documentation when applicable. **Inpatient Acute, Psychiatric and Skilled Nursing Facility (SNF) authorizations are subject to concurrent review.**

Authorization Request Instructions: Providers and facilities must be in network. Complete this form in its entirety, **include supporting clinical documentation** and fax it to Utilization Management at (888) 272-7656. Routine authorization requests are processed within 14 days. Medically Expedited Requests are processed within 72 hours. Please call (800) 474-1434 for authorization status. Authorization requests can also be submitted through the provider portal website. Please visit https://positivehealthcare.net/california/php-for-providers/ for additional information and instructions. Claim(s) will be paid if a prior authorization has been granted and member is eligible at time of service.

Medically Expedited/Urgent Requests: The definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent. Urgent/Expedited Requests that do not meet medical criteria will be downgraded to a standard request.

Eligibility Verification
For **PHP (HMO SNP)** (Medicare Advantage Part D plan) eligibility verification, please call (800) 263-0067.

Specialty Services Requiring Authorization

- Chemotherapy, photo and radiation therapy
- Dialysis in service area
- Durable medical equipment (DME)
- EMG, nerve conduction studies
- Part B Drugs
- Hearing aids
- Home health care, including skilled nursing, rehab, and home infusion
- Inpatient care (acute, subacute, SNF, and long-term)
- PET scans
- Out-of-Network Services
- Interventional radiology
- Meal Benefit
- Outpatient hospital services, surgery, and rehabilitation, including PT/OT/ST
- Orthotics and prosthetics
- Wound care

Date of Request:	☐ **Medically Expedited (subject to review)**		
Patient Information			
Member Name:	**Member ID Number:**	**Member Date of Birth:**	**Plan:** ☐ PHP CA
Referring Provider Information			
Name:	**Contact Name:**	**Phone:**	**Fax:**
Indication for Referral			
Diagnosis(es)/Code(s):			
CPT Code(s) & Quantity (if >1):			
List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data:			
Requested Consultation or Service:			
Specialty Provider Information			
Specialty Provider (PCP) Name:	**Specialty Phone:**	**Specialty Fax:**	