L.A. CARE HEALTH PLAN
PRE-AUTHORIZATION REQUEST FORM

If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain a copy of the criteria used to make this decision, please call 1-877-431-2273.

Please fax completed form to L.A. Care UM Department:

L.A. Care Use Only	
UM Database Log ID#:	
Provider Status:	☐ In-network ☐ Out-of-network
Member Language:	

Medi-Cal Auth. for Prior Fax: (213) 438-5777
Medi-Cal Urgent Fax: (213) 438-6100
Medi-Cal for Concurrent Right Fax: (877) 314-4957
Medicare Fax: (213) 438-5085
Health Integrated Fax: (877) 872-3161
Transplant Fax: (213) 438-5071
Case Management Fax: (213) 438-5034
COC Fax: (855) 351-9262

DATE:	**PCP:**	**PPG:**

LINE OF BUSINESS (check one): ☐ MCLA ☐ L.A. Care Covered ☐ Cal MediConnect ☐ Medicare dSNP ☐ PASC-SEIU ☐ Healthy Kids

PATIENT INFORMATION

MEMBER NAME:	**DOB:**	**MEMBER ID/SSN:**
ADDRESS:		**PHONE NUMBER:**
SERVICE IS: (Check one) ☐ **URGENT** (Within 72 hours) ☐ **ROUTINE** (Within 5 calendar days) ☐ **Post Service** (Within 30 calendar days)		**Preferred Language:**

REFERRAL – SERVICE TYPE REQUESTED

☐ DME (Expected Duration): ___________________________	☐ Major Diagnostic Procedure / Radiology	☐ SNF
☐ Home Health	☐ OB Care EDC: _________________________	☐ Specialist Consult / Treatment / Follow-Up Care
☐ Hospice	☐ Outpatient	☐ Surgical Procedure
☐ Inpatient	☐ Second Opinion	☐ Other: ____

PROVIDER SUBMITTING THIS REQUEST

REQUESTING PROVIDER NAME:		**SPECIALTY:**		**PHONE NUMBER:**	
ADDRESS:				**FAX NUMBER:**	

PROVIDER WHO WILL PERFORM / PROVIDE SERVICE

REQUESTED PROVIDER NAME:		**SPECIALTY:**		**PHONE NUMBER:**	
ADDRESS:				**FAX NUMBER:**	

DIAGNOSIS / PROCEDURE INFORMATION

ICD-9 CODE(S) / DESCRIPTION:	**CPT CODE(S) / DESCRIPTION:**	**HCPCS / DESCRIPTION:**

CLINICAL INDICATIONS FOR REQUEST: (INCLUDE PERTINENT PAST MEDICAL TREATMENT, PHYSICAL FINDINGS AND ATTACH ALL RELEVANT MEDICAL RECORDS AND TEST RESULTS, ETC.)

REQUESTING PROVIDER (PRINT): **SIGNATURE:** **DATE:**

OUT-OF-NETWORK REQUEST ONLY

WHEN REQUESTING AUTHORIZATION FOR SERVICES AT AN OUT OF NETWORK FACILITY, INCLUDE RATIONALE HERE:

L.A. CARE – UM USE ONLY

CLINICAL CRITERIA GUIDELINES MET:
☐ **YES** ☐ **NO** (If No, Medical Director Review Required)

AUTHORIZATION STATUS:
☐ **APPROVED** ☐ **REFER TO MEDICAL DIRECTOR** ☐ **See Comments:**

COMMENTS:

UM DEPARTMENT SIGNATURE: **DATE:**

MEDICAL DIRECTOR DECISION: ☐ **APPROVED** ☐ **DENIED** ☐ **MODIFIED**

COMMENTS:

MEDICAL DIRECTOR SIGNATURE: **DATE:**

Form Revised 2014-08-14

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE
Do not schedule non-emergent requested service until authorization is obtained.