DIFFICULT PLACEMENT (DPT) AUTHORIZATION FAX REQUEST FORM

L.A. Care HEALTH PLAN

DPT Fax: 213-438-5095
DPT Phone: 877-431-2273

☐ **Discharge order (Please include Hospital name, admit date and discharge date)**

☐ **Continued stay**

Complete *BOLDED required fields below to avoid delays in processing

***Request Date:**		
***Member ID:**	***Date of Birth:**	
***Member Name:**		
***Preferred Written Language:**	***PCP Name:**	
*PASRR Level 1 Screening Results: ☐ Positive for SMI or ID/DD/RC ☐ Negative *PASRR Level 2 Screening Results: ☐ Positive ☐ Negative ***We cannot process your request without PASRR results**	Screening Completed: ☐ Yes ☐ No	Date of Screening:
PASRR CID:	Screening Results:	

***Requesting Provider/Facility:**		***Specialty:**
***Phone Number:**	***Fax Number:**	***NPI:**
Address:	City:	Zip:

***Name of Requested Facility:**		***Contact Person:**	
***Phone Number:**	***Fax Number:**	***NPI:**	
***Address:**		***City:**	***Zip:**

***Level of Care requested, services needed, medical treatment, medications including frequency, route and end date if applicable:**

***Barriers to Discharge include:**

Attach all clinical indications for requested facility/level of care (request must include most current wound care, PTIOTISTIRT notes and discharge summary etc.):

Provider Name: (Print)	**Provider Signature:**	**Date:**

If the physician would like to discuss this case with the Medical Director or would like a copy of the criteria used to make this decision, please call the number listed on the fax cover sheet of your decision letter.

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE

Do not schedule non-emergent services until authorization is obtained