REVISED ICD-10 FORMS

AUTHORIZATION REQUEST FORM

L.A. Care HEALTH PLAN

Please fax completed form to appropriate L.A. Care UM Department fax number listed below:

Prior Authorization: (213) 438-5777 Urgent: (213) 438-6100 Concurrent: (877) 314-4957

Health Integrated: (877) 872-3161 Transplant: (213) 438-5071 Medicare: (213) 438-5077

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.

REQUEST INFORMATION				
Request Date:	Request Status:	☐ Urgent	☐ Routine	
Request Type (check one)	☐ Prior	☐ Concurrent	☐ Post Service	
Line of Business (check one):	☐ MCLA	☐ Cal MediConnect	☐ L.A. Care Covered	☐ PASC-SEIU ☐ Healthy Kids
PCP:		PPG:		
PATIENT INFORMATION				
Member Name:		Date of Birth:		
Preferred Language:		Member ID/SSN:		
Address:	City:	Zip:	Phone:	
REQUEST – SERVICE TYPE REQUESTED				
☐ DME Expected Duration:	☐ Hemodialysis	☐ Acute Hospital, Community		
☐ Prosthetic/Orthotics	☐ Ambulatory Surgery Center	☐ Acute Hospital, Tertiary		
☐ Home Health	☐ Diagnostic Procedure/Radiology	☐ Nursing Facility, short term skilled care		
☐ Hospice	☐ CBAS – Initial request	☐ Long Term Care		
☐ Transplant Evaluation				
☐ Other:				
PROVIDER SUBMITTING REQUEST				
Requesting Provider Name:		Specialty:		
Phone Number:		Fax Number:		
Address:	City:	Zip:		
PROVIDER PERFORMING/PROVIDING SERVICE				
Requested Provider Name:		Specialty:		
Phone Number:		Fax Number:		
Address:	City:	Zip:		
DIAGNOSIS/PROCEDURE INFORMATION *(Include ICD-10 on all requests prior to and after 10/1/2015)*:				
ICD-9 Code(s)/Description *(Prior to 10/1/2015):*				
ICD-10 Code(s)/Description				
CPT Code(s)/Description:				
HCPCS Code(s)/Description:				
Clinical Indications for request (include pertinent past medical treatment, physical findings and attach all relevant medical records, test results, etc.):				
Is the service being requested out of network?	☐ No	☐ Yes		
If yes, please provide reason for using an out of network facility:				
Provider Name: (Print)	Provider Signature:	Date:		