AUTHORIZATION REQUEST FORM

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

Prior Authorization: (213) 438-5777 Urgent: (213) 438-6100 Inpatient: (877) 314-4957 Delegate Support Team (DST): (213) 438-5761
Transplant: (213) 438-5071 Medicare: (213) 438-5077 CAN Network: (213) 438-5680

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
PATIENT INFORMATION			
Member Name:		Date of Birth:	
Preferred Written Language:		Member ID:	
Address:	City:	Zip:	Phone:
PCP:	PPG:		
Line of Business (check one):	❑ MCLA	❑ Cal MediConnect	❑ L.A. Care Covered ❑ PASC-SEIU
REQUEST – SERVICE TYPE REQUESTED			
❑ Acute Hospital, Community	❑ DME Expected Duration: _____		❑ Nursing Facility, short term skilled care
❑ Acute Hospital, Tertiary	❑ Hemodialysis		❑ Palliative Care
❑ Ambulatory Surgery Center	❑ Home Health		❑ Prosthetic/Orthotics
❑ CBAS - Initial request	❑ Hospice		❑ Transgender Health
❑ CBAS - Renewal	❑ Long Term Care – Initial Request		❑ Transplant Evaluation
❑ Diagnostic Procedure/Radiology	❑ Long Term Care – Renewal		❑ Other (Specify): _____
PROVIDER SUBMITTING REQUEST			
Requesting Provider Name:		Specialty:	
Phone Number:	Fax Number:		NPI:
Address:	City:		Zip:
PROVIDER PERFORMING/PROVIDING SERVICE			
Requested Provider Name:		Specialty:	
Phone Number:	Fax Number:		NPI:
Address:	City:		Zip:
DIAGNOSIS/PROCEDURE INFORMATION			
Clinical Indications for request (include pertinent past medical treatment, physical findings and attach all relevant medical records, test results, etc.):			
ICD-10 Code(s)/Description:			
CPT Code(s)/Description:			
HCPCS Code(s)/Description (If available):			
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:

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