PPG Member - AUTHORIZATION FAX REQUEST FORM

L.A. Care HEALTH PLAN

Both Routine and Urgent Fax: 877.453.9923 Phone: 844.917.7272 option 2		Routine Fax: 213.438.5777 Urgent Fax: 213.438.6100 Phone: 877.431.2273		Submit to PPG	
Acupuncture ☐	Hospice ☐	BH Therapy (ASD) ☐	Physician Administered Drugs ☐	Outpatient Surgery + Procedures ☐	
Chiropractic ☐	Insulin Pump ☐	CBAS ☐	Tertiary Services ☐	Planned Hospital Admissions ☐	
DME ☐	Medical Supplies ☐	Clinical Trials ☐	Transgender Services ☐	In-Office Procedures ☐	
Home Health ☐	Prosthetics ☐	Long Term Care ☐	Transplant-Eval/Workup/Surgery ☐	Specialist Visits / Consults ☐	
		Palliative Care ☐	Transportation ☐		

Please complete all sections of this form for fastest processing. Include appropriate clinical and provider contact information and other relevant documents related to medical necessity.

If this request is for an extension or modification of an existing authorization, please provide the original authorization number here: _____

Request Date: **Request Type:** ☐ **Routine** ☐ **Urgent** ☐ **Post Service** ☐ **Inpatient**

Patient Demographics:

Member Name: Date of Birth:

Preferred Written Language: Member ID:

Address: City: Zip: Phone:

PCP: PPG:

Requesting Provider/Facility:

Requesting Provider/Facility: Specialty:

Phone Number: Fax Number: NPI:

Address: City: Zip:

Servicing Provider/Facility: **To find an in-network Provider please visit** http://www.lacare.org/find-doctor-or-hospital

Servicing Provider/Facility: Specialty:

Phone Number: Fax Number: NPI:

Address: City: Zip:

Diagnosis:

ICD-10 Code(s)/Description:

CPT/HCPC Codes	CPT/HCPC Code	CPT/HCPC Code	CPT/HCPC Code
Acupuncture _____	Hospice _____	Palliative Care _____	Transgender _____
CBAS _____	In-Office Proc. _____	Phys Admin drug _____	Transplant _____
Chiropractor _____	Insulin Pump _____	Planned Admit _____	Transportation _____
Clinical Trial _____	Long Term Care _____	Prosthetics _____	Other _____
DME _____	Medical Supplies _____	Specialty Visit _____	**Additional Codes**:
Home Health _____	OB Care _____	Tertiary Service _____	_____

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:

Print Requesting Provider Name: Provider Signature: Date:

If the physician would like to discuss a case with the Medical Director or would like a copy of the criteria used to make a 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