L.A. Care | Direct Network — A Direct Partnership for all of L.A.

☐ AUTHORIZATION FAX REQUEST FORM
☐ REFERRAL FORM

If you are a PCP or Specialist requesting a referral to an In-Network Provider, mark the Referral box above. NO PRIOR AUTH REQUIRED for these services. Fax a copy of this Referral and clinical notes to the In-Network Servicing Provider to notify them of the Referral. Your patient can then call for an appointment.

Outpatient and Elective Services Routine / Post Service Fax: 213-438-5777 Urgent Fax: 213-438-6100			Behavioral Health Fax: 213-438-5054	CBAS Fax: 213-438-5739
☐ Acupuncture	☐ Hospice	☐ PT / OT / ST	☐ BH Therapy / ASD	☐ Community Based Adult Services
☐ Chiropractic	☐ Laboratory / Pathology	☐ Radiology		
☐ Clinical Trials	☐ Palliative Care	☐ Specialty Referral	**LTC Fax: 213-438-4877**	**Transportation Fax: 213-438-2201**
☐ DME/Supplies	☐ Pharmacy	☐ Transgender Services		
☐ Elective Procedures	☐ Private Duty Nursing	☐ Transplant-Eval, Surgery	☐ Long Term Care	☐ Non- Emergency Medical Transport
☐ Home Health	☐ Prosthetics	☐ Other		

Not sure whether service requires prior authorization? Use our code look-up tool https://www.lacare.org/providers/provider-resources/prior-authorization-search
Any questions? Call the L.A. Care UM call center at 877-431-2273.

Complete *BOLDED required fields below to avoid delays in processing

Member Information		
***Member ID:**	***Date of Birth:**	
***Member Name:**		
Requesting Provider Information		
To find an in-network Provider please visit http://www.lacare.org/find-doctor-or-hospital		
***Request Date:**	***Request Type:** ☐ **Routine** ☐ **Urgent** ☐ **Post Service**	
***Date(s) of Service:**		
***Requesting Provider:**	***Specialty:**	
***Phone Number:**	***Fax Number:**	***NPI:**
***Address:**	***City:**	***Zip:**
Servicing Provider Information		
***Servicing Provider:**	***Specialty:**	
***Phone Number:**	***Fax Number:**	***NPI:**
***Address:**	***City:**	***Zip:**
***Place of Service:** ☐ **Inpatient** ☐ **Outpatient** ☐ **ASC** ☐ **Office** ☐ **Other:**		
Facility Provider Information (if applicable)		
***Servicing Facility:**		
***Phone Number:**	***Fax Number:**	***NPI:**
***Address:**	***City:**	***Zip:**
***List ICD-10 Codes below:**		

***CPT / HCPCS Codes / Descriptions for service(s) REQUIRING Authorization**		
***Clinical Indications** (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:		
Print Requesting Provider Name:	Provider Signature:	Date:

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