L.A. Care Direct Network - AUTHORIZATION FAX REQUEST FORM

Routine & Urgent Fax: 213.438.5680 Phone: 844.917.7272 Option 2 For ***fastest*** processing https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces			Routine Fax: 213.438.5777 Urgent Fax: 213.438.6100 Phone: 877.431.2273 Option 2	
Acupuncture	Hospice	Outpatient Procedure	BH Therapy (ASD)	Physician Administered Drugs
Ambulatory Procedures	Imaging	Outpatient Surgery	CBAS	Tertiary Services
Chiropractic	In-Office Procedures	Planned Hospital Admission	Clinical Trials	Transgender Services
DME	Insulin Pump	Prosthetics	Long Term Care	Transplant-Evaluation/Workup/Surgery
Home Health	Medical Supplies	Specialty Visit/Consult	Palliative Care	Transportation

Complete *BOLDED required fields below to avoid delays in processing

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** ☐ ***Referral***	
***Member ID:**	***Date of Birth:**	
***Member Name:**		
***Preferred Written Language:**	***PCP Name:**	
***Requesting Provider/Facility:**		***Specialty:**
***Phone Number:**	***Fax Number:**	***NPI:**
Address:	City:	Zip:
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:**
***List ICD-10 Codes below:**		

If you are a PCP or Specialist requesting a referral to an In-Network Provider, mark the Referral box above. There is NO 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.

***CPT / HCPCS Codes / Descriptions for service(s) REQUIRING Authorization**	**In-Network Referrals DO NOT require prior Auth**
	THIS INCLUDES: *ALL* Specialty consults and follow-up visits
	Total OB Care, Well Woman, Family Planning Services
	Routine Radiology, x-rays, ultrasounds, EKGs, echos
	Routine Lab services, preps & tests: CBC, metabolic panels
	(Please note the service(s) for this Referral below)

***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:

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