☐ **Prior Authorization Fax Request Form ~OR~**

☐ **Referral Form (*L.A. Care Direct Network Only*)**

If you are a PCP or Specialist requesting a referral to an In-Network Provider, mark the box above for *Referral Form* there is NO PRIOR AUTH REQUIRED for this referral.
Fax a copy of this Referral and your Clinical notes to the In-Network Servicing Provider to notify them of your Referral and direct your patient to call for an appointment.
Fax a copy of this Referral form to L.A. Care at 213-335-5019

☐ **Referral Form for Standing Referrals (*L.A. Care Direct Network Only*)**

Standing referrals may be needed for members with a condition that requires specialized care over an extended amount of time. If you are a PCP or Specialist requesting a standing referral to an In-Network Provider, mark the box above for *Referral Form for Standing Referrals*. NO PRIOR AUTH REQUIRED for these services.
FAX this referral along with clinical notes to the In-Network Servicing Provider AND to L.A. Care at 213-335-5019

| **Outpatient and Elective Services**<br>**Routine / Post Service Fax: 213.438.5777 / Urgent Fax: 213.438.6100** | | | | **Behavioral Health Fax: 213-438-5054** |
|---|---|---|---|---|
| ☐ Acupuncture<br>☐ Chiropractic<br>☐ Clinical Trials<br>☐ DME/Supplies<br>☐ Home Health | ☐ Hospice<br>☐ IP Surgery<br>☐ Laboratory / Pathology<br>☐ OP Surgery<br>☐ Palliative Care | ☐ Pharmacy<br>☐ Private Duty Nursing<br>☐ Prosthetics<br>☐ PT / OT / ST<br>☐ Radiology | ☐ Specialty Referral<br>☐ Transgender Services<br>☐ Transplant Eval to Surgery | ☐ BH Therapy / ASD |
| | | | | **CBAS Fax: 213-438-5739** |
| | | | | ☐ Community Based Adult Services |
| **LTC / SNF / ICF Fax: 213-438-4877** | | | | **Transportation Fax: 213-438-2201** |
| **PASRR results required for:**<br>**PASRR results not required for:** | ☐ Long Term Care<br>☐ ICF/DD | ☐ Subacute Care – Adults<br>☐ ICF/DD-H | ☐ Subacute Care – Pediatrics<br>☐ ICF/DD-N | ☐ Non- Emergency Medical Transport |

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 | | |
| ***Requesting Provider:** | ***License:** | ***NPI:** | ***TIN** |
| ***Phone Number:** | ***Fax Number:** | | |
| ***Address:** | ***City:** | | ***Zip:** |
| ***Starting Service Date:** | ***Ending Service Date:** | | |
| **Servicing Provider Information** | | | |
| ***Servicing Provider:** | ***License:** | ***NPI:** | ***TIN** |
| ***Phone Number:** | ***Fax Number:** | ***Specialty:** | |
| ***Address:** | ***City:** | | ***Zip:** |
| ***Place of Service:** ☐ Office ☐ Home ☐ Inpatient ☐ Outpatient ☐ Other: | | | |
| **Facility Provider Information (if applicable)** | | | |
| ***Servicing Facility:** | | ***NPI:** | |
| ***Phone Number:** | ***Fax Number:** | | |
| ***Address:** | ***City:** | | ***Zip:** |
| ***List ICD-10 Codes:** | | | |
| | | | |
| ***CPT / HCPCS Codes for requested service(s) including Quantity:** Describe clinical Indications & include pertinent past medical treatment, physical findings and attach all relevant medical records. | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Is the service being requested Out of Network? ☐ *No* ☐ *Yes* If yes, please provide reason for Out of Network facility/provider: | | | |
| **Print Requesting Provider Name:** | **Provider Signature:** | | **Date:** |

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**AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE – DO NOT SCHEDULE NON-EMERGENT SERVICES UNTIL AUTHORIZATION IS OBTAINED**