

PACIFIC HEALTH ALLIANCE

PRE-AUTHORIZATION FORM

IF MEDICAL RECORDS ARE NOT RECEIVED WITH THIS FORM IT WILL NOT BE REVIEWED. PLEASE COMPLETE THE FORM IN ITS ENTIRETY. TAX ID AND CPT CODES MUST BE INCLUDED.

PHONE: (855) 754-7271 FAX: (650) 425-9468

Date of Request: _____

Urgent (24 hours) Check this box only when following the standard time frame could seriously jeopardize the member's life or health.

Member Information

Health & Welfare Plan Name: _____ Member's Plan Network: _____

Member Name: _____ DOB: _____ MID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Member Phone: _____ Medicare Primary: Yes No Other Insurance: Yes No

Requesting Provider Information

Requesting Provider: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

TAX ID #: _____ NPI: _____ Requesting Provider Signature: _____ Date: _____

YOUR NAME: _____ CONTACT PHONE: _____ Is this provider contracted with the member's plan? Yes No

Diagnosis: _____ ICD.10 _____

Requested Service: _____ Quantity of visits, if applicable: _____

CPT/HCPC Codes: _____

Facility Information

FACILITY/SPECIALIST: _____ TAX ID #: _____ NPI: _____

Is the facility/specialist contracted with member's plan? Yes No

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Expected Date of Service: _____ Is this a retro authorization? If so, please indicate date/range: _____

Office Inpatient Services Outpatient Services 23 Hour Short Stay

PHA USE ONLY - DO NOT WRITE BELOW THIS LINE!!!!!!

Approved # of Visits: _____ Interqual Guidelines Met # _____

Authorization Number: _____ Valid From: _____ to _____ Expiration Date

Denied Denial Reason: _____

Other _____

Medical Director Signature

Case Manager/Care Counselor Signature

Date

Authorization is subject to eligibility & benefits on date of service. There is no guarantee of payment

To ensure proper payment for services rendered, please verify eligibility on date of service. If member is determined to be ineligible on date of service, they may be responsible for payment of these services. Please contact the number listed on the patient card to verify eligibility.

Send all claims to the address listed on the patient ID card