Print Form

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