



## MEDI-CAL MANAGED CARE REQUEST FOR PRIOR AUTHORIZATION

FAX completed form with relevant clinical information attached to (833)853-8550  
For questions, call (559)228-2905 or toll free at (833)513-0622

Select health plan:

- ☐ Anthem Blue Cross Medi-Cal Managed Care  
☐ Health Net CalViva California Medi-Cal

### SERVICES REQUIRING PRIOR AUTHORIZATION (select requested service)

- |  |   |
|--|---|
| <input type="checkbox"/> Bariatric Surgery               | <input type="checkbox"/> Injections – Self-Injections                         |
| <input type="checkbox"/> Colonoscopy, EGD, Manometry     | <input type="checkbox"/> Injections – In-Office Injections                    |
| <input type="checkbox"/> Cosmetic/Reconstructive Surgery | <input type="checkbox"/> MRI, MRA, CT & PET Scans                             |
| <input type="checkbox"/> DME Purchase over \$500         | <input type="checkbox"/> Out-of-Plan Provider                                 |
| <input type="checkbox"/> DME Rental                      | <input type="checkbox"/> Sleep Studies  |
| <input type="checkbox"/> Genetic Testing                 | <input type="checkbox"/> Transplants in conjunction with Health Plan Programs |
| <input type="checkbox"/> Home Infusion                   | <input type="checkbox"/> Varicose Vein Treatment                              |
| <input type="checkbox"/> Infusions - Ambulatory          | <input type="checkbox"/> Wound Care – Facility Based                          |

### TYPE OF REQUEST

- ☐ **NON-URGENT** for routine or elective services      ☐ **URGENT** if imminent threat to life or health exists requiring care within 72 hours or less

### PATIENT INFORMATION

<b>Patient Name:</b> (Last, First, MI)		<b>Date of Birth:</b> (MM/DD/YY)	
<b>I.D.#:</b>	<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>PCP:</b>	

### FROM – REQUESTING PHYSICIAN

<b>Requesting Physician:</b>		<b>NPI:</b>	<b>Tax ID:</b>
<b>Contact Person:</b>	<b>Phone:</b>	<b>Fax:</b>	
<b>Physician Signature:</b>		<b>Date:</b>	

### TO – WHERE WILL PATIENT RECEIVE SERVICES?

<b>Physician/Provider/Facility Requested:</b>	<b>NPI:</b>	<b>Tax ID:</b>
<b>Where will services be rendered?</b> (provide name of facility, if other than provider office or patient's home)		
<b>Address:</b>	<b>Phone:</b>	<b>Fax:</b>

### CLINICAL INFORMATION

<b>ICD-10 Codes:</b> 1                      2                      3	<b>Diagnosis Description:</b>	
<b>CPT/HCPC Codes:</b> 1                      2                      3	<b>Describe Service Requested:</b>	<b># of Days/Visits:</b>
<b>Comments:</b>		

*Within 2 days before the actual date of service, provider MUST confirm that the member's health plan coverage is still in effect. With the exception of urgent requests, it is recommended that you do not schedule appointments prior to authorization approval. Emergency services do not require prior authorization and are reviewed retrospectively for necessity. This message is intended only for the use of the individual/entity to which it is addressed and may contain confidential information. If the reader of this message is not the intended recipient, you are hereby notified that any distribution is strictly prohibited.*

EFFECTIVE DECEMBER 2020