P.O. Box 8350
La Verne, CA 91750

Phone: (888) 293-6383
Fax (Auths): (833) 813-7600
Inpatient Auths: (888) 320-3851

Request Date: _____

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE ☐ URGENT ☐ RETRO ☐ ADMISSION Notification

Urgent requests based on scheduling convenience could potentially endanger other patients who meet the clinical criteria for an urgent request. Urgent referral requests are for medical care where applying the normal timeframe (5 days) is detrimental to the patient's life/health, or jeopardize patient's ability to regain maximum function or result is loss of Life, or Limb, or Major bodily function.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Member ID : _____ Member's Health Plan : _____

Name of Facility (if applicable): _____

Requesting Provider:	Servicing/Requested Provider (Physician, Facility, Vendor):
Provider NPI# _____ Provider TIN#: _____	Provider NPI#: _____ Provider TIN#: _____
Address: _____ Phone: _____ _____ Fax: _____	Address: _____ Phone: _____ _____ Fax: _____
Office Contact: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

PROVIDER: Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered.

AUTHORIZATION REQUEST

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

☐ Inpatient Facility ☐ Surgery Center/OP ☐ SNF ☐ Medical Services/Items ☐ Part B Drugs

Date(s) of Service: _____ Inpatient Admission Date: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	UNITS (REQUIRED)

DO NOT WRITE BELOW THIS LINE

STATUS		Authorization Number #:	
☐ Approved	☐ Alternative Treatment	Signature:	Date:
☐ Not a Covered Benefit	☐ Modified	Comments:	
☐ Not Medically Indicated		Phone:	

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