



Retrospective requests will not  
be honored through use of this form.

Request Date: \_\_\_\_\_

## AUTHORIZATION REQUEST FORM (ARF)

Standard       Expedited       Admissions Notification

Physician Administered Drugs:  Medi-Cal injectable or infusion       Medicare Part B Drug Standard       Medicare Part B Drug Expedited

Expedited requests based on scheduling convenience could **potentially endanger other patients** who meet the clinical criteria for an urgent request. Expedited referral requests are for medical care where applying the normal timeframe (7 days) is detrimental to the patient's **life/health** or jeopardize patient's ability to **regain maximum function** or results in loss of **Life, or Limb, or Major Bodily Function**.

Expedited requests: I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or pain.

**EXPEDITED REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY**

X: \_\_\_\_\_

Patient Name (Last, First): \_\_\_\_\_  Male       Female  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Patient Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Patient Phone: \_\_\_\_\_ Member ID & Health Plan: \_\_\_\_\_

Requesting Provider Name: _____  Provider NPI #: _____ Provider TIN #: _____ Address: _____ Phone: _____ _____ Fax: _____ Office Contact Name & Role: _____	Servicing/Requested Provider: _____  Provider NPI #: _____ Provider TIN #: _____ Address: _____ Phone: _____ _____ Fax: _____ Office Contact Name & Role: _____
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Servicing/Requested Facility (if applicable): \_\_\_\_\_  
Facility NPI #: \_\_\_\_\_ Facility TIN #: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact Name & Role: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

**Notice to Provider:** Authorization does not guarantee payment, ELIGIBILITY must be verified prior to services rendered.

### AUTHORIZATION REQUEST

\*\*\*IN ORDER TO PROCESS YOUR REQUEST, THIS FORM MUST BE COMPLETED AND LEGIBLE\*\*\*

Inpatient Facility     Office     SNF     Surgery Center / Outpatient     Medical Services/Items

Inpatient Admission Date (if applicable): \_\_\_\_\_

List ALL procedures requested along with the appropriate CPT/HCPCs and **submit supporting Medical Records.**

Requested Procedures	Code (CPT or HCPC)	Modifiers	Units (Required)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____