AUTHORIZATION REQUEST FORM

Please fax completed form to appropriate L.A. Care UM Department fax number listed below:

Prior Authorization: 213.438.5777 **Urgent:** 213.438.6100 **Inpatient:** 1.877.314.4957 **Delegate Support Team (DST):** 213.438.5761
Transplant: 213.438.5071 **Medicare:** 213.438.5077 **L.A. Care Direct Network:** 213.438.5680

If the treating physician would like to discuss this case with the physician or health care professional reviewer or would like to obtain a copy of the criteria used to make this decision, please call **1.877.431.2273**.

Request Information		
Request Date:	Request Status:	
Request Type: (check one) ☐ Urgent ☐ Routine ☐ Prior ☐ Concurrent ☐ Post Service		
Patient Information		
Member Name:	Date of Birth:	
Preferred Written Language:	Member ID:	
Address: City:	Zip:	Phone:
PCP:	PPG:	
Line of Business (check one): ☐ Medi-Cal ☐ Cal MediConnect ☐ L.A. Care Covered ☐ PASC-SEIU		
Request - Service Type Requested		
☐ Acute Hospital, Community	☐ DME Expected Duration:	☐ Palliative Care (not hospice)
☐ Acute Hospital, Tertiary	☐ Hemodialysis	☐ Prosthetic/Orthotics
☐ Ambulatory Surgery Center	☐ Home Health	☐ Transgender Health
☐ CBAS - Initial request	☐ Hospice	☐ Transplant Evaluation
☐ CBAS - Renewal	☐ Long Term Care – Initial Request	☐ Other (Specify):
☐ Clinical Trial (not investigational)	☐ Long Term Care – Renewal	
☐ Diagnostic Procedure/Radiology	☐ Nursing Facility, short term skilled care	
Provider Submitting Request		
Requesting Provider Name:	Speciality:	
Phone Number:	Fax Number:	NPI:
Address:	City:	Zip:
Provider Performing/Providing Service		
Requested Provider Name:	Speciality:	
Phone Number:	Fax Number:	NPI:
Address:	City:	Zip:
Diagnosis/Procedure Information		
Clinical Indications for request (include pertinent past medical treatment, physical findings and attach all relevant medical records, test results, etc.):		
ICD-10 Code(s)/Description:		
CPT Code(s)/Description:		
HCPCS Code(s)/Description (If available):		
Is the service being requested out of network? ☐ No ☐ Yes		
If yes, please provide reason for using an out of network facility:		
Provider Name (Print First and Last Name):	Provider Signature:	Date:

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE
Do not schedule non-emergent requested service until authorization is obtained.