P.O. Box 8350
La Verne, CA 91750

Phone: (888) 293-6383
Fax: (888) 320-3851

Request Date: _____

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE ☐ URGENT ☐ RETRO ☐ ADMISSION Notification

FAX COMPLETED FORM TO (888) 320-3851

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 : _____ Name of Facility (if applicable): _____

Requesting Provider:	Servicing/Requested Provider (Physician, Facility, Vendor):
Provider NPI# _____	Provider NPI#: _____
Provider TIN#: _____	Provider TIN#: _____
Address: _____ Phone: _____	Address: _____ Phone: _____
_____ Fax: _____	_____ 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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