# 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.*