

PRIOR AUTHORIZATION (PA) Request Form

Fax completed form to 888-972-1931

Please note: Incomplete request form without supporting clinical notes will delay the determination process. Determination Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the requested provider.

IPA NAME:	
<input type="checkbox"/> MCP-Premier Patient Care IPA (CHP/Champion/IHP)	<input type="checkbox"/> Premier Patient Care IPA (Direct with Hnet/Molina/IHP)
<input type="checkbox"/> Physician Partners	<input type="checkbox"/> MCP-Hana Care IPA (aka NCPG)
<input type="checkbox"/> PremierCare IPA	<input type="checkbox"/> Medicare (MCP) Direct

Type of Request: **ROUTINE** **URGENT** (medical condition that requires immediate intervention only) **RETRO**

MEMBER INFORMATION		Date: <input style="width: 100px;" type="text"/>
Patient Name: <input style="width: 300px;" type="text"/>	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: <input style="width: 100px;" type="text"/>
Patient's Address: <input style="width: 150px;" type="text"/> <input style="width: 150px;" type="text"/> <input style="width: 150px;" type="text"/>		
Phone: <input style="width: 100px;" type="text"/>	Health Plan Name: <input style="width: 150px;" type="text"/>	Health Plan Member ID #: <input style="width: 100px;" type="text"/>
Subscriber Name: <input style="width: 150px;" type="text"/>	Member's Primary Care Provider: <input style="width: 150px;" type="text"/>	

REQUESTING PROVIDER	REQUESTED PROVIDER & FACILITY
Name: <input style="width: 90%;" type="text"/>	Name: <input style="width: 90%;" type="text"/>
Type of Specialty: <input style="width: 90%;" type="text"/>	Type of Specialty: <input style="width: 90%;" type="text"/>
Address: <input style="width: 90%;" type="text"/>	Address: <input style="width: 90%;" type="text"/>
City, State, ZIP: <input style="width: 90%;" type="text"/>	City, State, ZIP: <input style="width: 90%;" type="text"/>
Phone: <input style="width: 50px;" type="text"/> Fax: <input style="width: 50px;" type="text"/>	Phone: <input style="width: 50px;" type="text"/> Fax: <input style="width: 50px;" type="text"/>
Contact Name: <input style="width: 90%;" type="text"/>	Tax ID # (Non-Contracted): <input style="width: 100px;" type="text"/>
Today's Date: <input style="width: 100px;" type="text"/>	Place of Service: <input style="width: 100px;" type="text"/>

REQUESTED SERVICES AND MEDICAL NECESSITY
Diagnosis Description(s): <input style="width: 90%;" type="text"/>
ICD-10(s): <input style="width: 90%;" type="text"/>
Reason for Referral: <input style="width: 90%;" type="text"/>
<i>Attach supporting documentation: (recent clinical notes, physical exam, labs, Diagnostic study results, pictures/images with measurements)</i>

Requested Service(s)	Description	CPT	# Units
Requested Service(s):	<input style="width: 95%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>
	<input style="width: 95%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>
	<input style="width: 95%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>
	<input style="width: 95%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed.
- Providers are responsible to verify member eligibility to ensure coverage. Approved Authorization is not a guarantee of payment.
- Claims for services rendered without required prior authorization may be denied or delayed reimbursement.
- Claims for the above services must be submitted for the same CPT code(s), unit #, and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to Premier Patient Care IPA- UM Dept at fax at 888-972-1931. For any questions, please call our UM Department at (657)-206-8700 select Outpatient Authorization.

This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety code §1370, and California Evidence Code §
 CONFIDENTIAL: This facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited.