Health Plan of San Joaquin

AUTHORIZATION FORM

Please check Line of Business	☐ Medi-Cal	☐ Inpatient _____ Days ☐ Outpatient ☐ Office Visit

Service requiring Health Plan Approval must be submitted on this form.

Payment is subject to member eligibility and medical necessity determination.

Please confirm eligibility by calling: (209) 942-6320 or **IVR (209) 942-6303**

Fax this authorization and supporting documents to the Health Plan's UM Department.

Inpatient Fax (209) 762-4702 San Joaquin

Inpatient Fax (209) 762-4703 Stanislaus

Outpatient Fax (209) 942-6302

Please fill-in all requested information for timely processing of your request. Completed by: _____

☐ ROUTINE ☐ URGENT	☐ PCP	☐ Specialist	
PATIENT	**REQUESTING PROVIDER**	**NPI**	**TIN**
Name *(Last, First)*	**Name**		
Health Plan Member ID No.	**Street Address**		
Date of Birth *(MM/DD/YY)* **Sex:** ☐ Male ☐ Female	**City, State, Zip**		
Appointment Date	**Phone**	**Fax**	

AUTHORIZE TO (Service Provider)

Provider (Practitioner)	**Group / Pay To / Facility**	
Specialty	**Phone**	**Fax**
Address	**City, State, Zip**	

REQUIRED INFORMATION FOR SERVICE PROVIDERS: **Provider NPI #** _____ **Tax ID:** _____ **Facility/ Group NPI** _____

Comments:

REASON FOR AUTHORIZATION REQUEST: Please indicate the quantity ( ) you are requesting for each CPT/HCPS code. If no quantity indicated the default amount will be "1".

ICD-						
Some ICD- codes DUH UHSRUWHG WR WKHLU KLJKHVW QXPEHU RI FKDUDFWHUV DYDLODEOH				*RU Please document diagnosis completely.*		
CPT/HCPCS Code [Quantity]	( )	( )	( )	( )	( )	
Modifier Required for DME						

Date: _____ **Requesting Provider Signature:** _____