Health Plan of San Joaquin

Mountain Valley Health Plan

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 ☐ RETROSPECTIVE REVIEW ☐ 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:** _____