# Authorization Form

Health Plan of San Joaquin | Mountain Valley Health Plan

| | | | |
|---|---|---|---|
| **Please check Line of Business:** | ☐ Medi-Cal | ☐ Inpatient _____ days<br>☐ Outpatient | ☐ Office Visit<br>☐ Other: _____ |

**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 Health Plan's UM Department.

**Inpatient Fax**
209-762-4702
**Outpatient Fax**
209-942-6302

**Please fill-in all requested information for timely processing of your request.**

**Completed by:** _____

| | | | |
|---|---|---|---|
| ☐ **Routine**<br>☐ **Urgent** | ☐ **Retrospective Review** | ☐ **PCP** | ☐ **Specialist** |

| **PATIENT** | | **REQUESTING PROVIDER** | **NPI:** | **TIN:** |
|---|---|---|---|---|
| **Name:** *Last, First* | | **Name:** | | |
| **Health Plan Member ID#:** | | **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-10** | | | | | |
| *Some ICD-10 codes are reported to their highest number of characters available (3, 4, 5, 6, or 7). Please document diagnosis completely.* | | | | | |
| **CPT/HCPCS Code (Quantity)** | ( ) | ( ) | ( ) | ( ) | ( ) |
| **Modifier Required for DME** | | | | | |

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