Health Net®
COMMUNITY SOLUTIONS

Request for Prior Authorization for Health Net Medi-Cal Members

Instructions: Use this form to request prior authorization for Medi-Cal members. This form is **NOT** for commercial, Medicare, Health Net Access, or Cal MediConnect members. **Type** or **print;** complete all sections. **Attach sufficient clinical information** to support medical necessity for services, or your request may be delayed. **Fax the completed form to the Health Net Medi-Cal Prior Authorization Department at 1-800-743-1655.**

MEMBER INFORMATION

Member name: Last First MI Date of birth: (Mo/Day/Yr)

Subscriber #:

Check appropriate box.

CCS-eligible condition: ☐ Yes ☐ No
Other insurance/policy #: ☐ Work-related ☐ Auto accident

Designate type of request. Check appropriate box(es).

☐ **Elective** for routine, non-urgent services.

☐ **Urgent/Expedited**: Needed urgently; if not, could seriously jeopardize the life/health or ability of member to regain maximum function or, in your opinion, would subject member to severe pain that cannot be adequately managed without the service/treatment requested below.
Explain clinical necessity for urgent request. _____

☐ Notification only, for dialysis or prenatal maternity care (estimated date of confinement (EDC)) _____.

☐ Confidential request: Member/provider requests confidentiality. Health Net will not mail service-confirmation letter to member.

☐ Post-service *request* – prior to claim submission.

Designate service requested. Check appropriate box.

☐ Office procedure
☐ Outpatient service/surgery
☐ Clinical trial
☐ Inpatient services
☐ DME
☐ Other _____

Anticipated date of service: _____

☐ Transplant evaluation for pediatric
☐ Transplant
☐ Initial outpatient rehabilitative____/habilitative____services (PT, OT, ST)
– Initial home health: Is member homebound? Yes ☐ No ☐
☐ Continued outpatient rehabilitative___/habilitative___services (HH/PT/OT/ST)
– Remaining authorized visits? ____ Does plan have volume limits?_____
Has member used or will he/she use last visit within the next 24 hours? Yes☐ No☐

PROVIDER INFORMATION

Requesting/Ordering Provider Information			**Servicing Provider – Where will member receive services?**	
First and last name of requesting provider			Name of hospital or provider of services/product (no abbreviations)	
Tax ID # of above	National Provider Identifier of above		Tax ID # of above	National Provider Identifier of above
Address			Address	
City/State/ZIP			City/State/ZIP	
Area Code	Telephone # + EXT.	Fax #	Area Code	Telephone # of above + EXT.
Requesting/Ordering Contact Name (REQUIRED)		Telephone # + EXT	Assistant surgeon required? Yes ☐ No ☐	
Name of primary care physician (PCP) (if applicable)			Assistant surgeon name NPI Tax ID	
Area Code	Telephone # + EXT.	Fax #	Anesthesiologist required? Yes ☐ No ☐	

CLINICAL INFORMATION

ICD-10 code(s) (REQUIRED):	Diagnosis description:	Date of onset/injury:
CPT/HCPCS code(s) (REQUIRED):	# of visits:	Describe service requested (Note: Billed CPT codes not approved require clinical review upon submission of claim and report.):

Why is the service necessary? (Attach diagnostics, X-ray reports, progress notes, results of conservative treatment.)

Is the member terminally ill (life expectancy less than 6 months)? Yes ☐ No ☐ N/A ☐ Is the member aware? Yes ☐ No ☐ N/A ☐

Signature of requesting physician: Date:

Note: Provider agrees that the results of the care or treatment rendered under approved authorization shall be forwarded to the requesting physician or primary care physician named above for inclusion in the patient's medical record. Health Net uses evidence-based information and national guidelines to make authorization decisions. Contracting provider agrees to accept Health Net's payment as payment in full and will not bill the member for any amount for services rendered hereunder except for member copayments, deductibles and coinsurance required under the member's plan. This form is not a guarantee of payment. Charges for services rendered to patients whose coverage is no longer in effect are the patient's responsibility. Patient eligibility and covered benefits must be verified before rendering any medical services at www.healthnet.com.

PPG USE ONLY (for use only by delegated groups) Do not use for fee-for-service (FFS) membership.

PPG UM Dept. **original** received: Date: Time: Type: ☐ Expedited ☐ Routine	Reason sent to Health Net: ☐ OON ☐Investigational/experimental ☐ Other: ____	Pended: ☐Yes ☐ No If "Yes," attach pend letter.	Date add'l info rec'd: