



OUTPATIENT CALIFORNIA MEDI-CAL AUTHORIZATION FORM



Request for additional units. Existing Authorization Units

Complete & Fax to: 1-800-743-1655
Transplant Fax to: 1-833-769-1141

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

*** INDICATES REQUIRED FIELD** URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

Last Name, First

*Date of Birth

MEMBER INFORMATION

*Member ID (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

 Requesting Provider Contact Name

*Requesting NPI *Requesting TIN Phone

Requesting Provider Address *Fax

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider Servicing Provider Contact Name

*Servicing NPI *Servicing TIN Phone

Servicing Provider/Facility Name Address Fax

City, State, Zip

AUTHORIZATION REQUEST

*Primary Procedure Code Additional Procedure Code *Start Date OR Admission Date *Diagnosis Code

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY) (ICD-10)

Additional Procedure Code Additional Procedure Code End Date OR Discharge Date Total Units/Visits/Days

(CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MMDDYYYY)

(Enter the Service type number in the boxes)

*OUTPATIENT SERVICE TYPE

- | | | |
|---|---------------------------|---|
| 199 Adult Day Care | 997 Office Visit/Consult | 127 Speech Therapy Evaluation (nonpar only) |
| 422 Biopharmacy | 794 Outpatient Services | 701 Speech Therapy |
| 712 Cochlear Implants & Surgery | 171 Outpatient Surgery | 790 Occupational Therapy |
| 299 Drug Testing | 428 Second Opinion | |
| 922 Experimental and Investigational Services | 201 Sleep Study | |
| 205 Genetic Testing & Counseling | 993 Transplant Evaluation | DME |
| 290 Hyperbaric Oxygen Therapy | 209 Transplant Surgery | 417 Rental |
| 141 Imaging | 724 Transportation | 120 Purchase |
| 112 Nutritional Supplements and/or Services | 971 Physical Therapy | |
| 279 Occupational Therapy Evaluation | Evaluation (nonpar only) | |
| 101 Physical Therapy | | (Purchase Price) |

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.
Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Outpatient Authorization Supplemental Form

This page is optional and meant to be used when an authorization request exceeds more than four (4) Procedure Codes. When applicable, please submit this form with the Outpatient Prior Authorization Form to the applicable fax number.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

* Medicaid/Member ID

Last Name, First

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

AUTHORIZATION REQUEST

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.