OUTPATIENT CALIFORNIA HEALTHNET COMMERCIAL AUTHORIZATION FORM

health net

Complete and **Fax** to: 1-844-694-9165
Transplant **Fax** to: 1-833-769-1142

☐ HMO
☐ POS
☐ PPO

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ **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** X ______ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

MEMBER INFORMATION

Last Name, First

*Date of Birth (MMDDYYYY)

*Member ID

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 (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

***Start Date** OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

(Enter the Service type number in the boxes) ☐☐☐

*OUTPATIENT SERVICE TYPE

412 Auditory
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyberbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
211 OB Ultrasound

410 Observation
997 Office Visit/Consult
210 Orthotics
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health
533 BH Applied Behavioral Analysis
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME
417 Rental
120 Purchase
(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.

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

* Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

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
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