CalViva HEALTH

OUTPATIENT CALIFORNIA *MEDI-CAL* AUTHORIZATION FORM

health net

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**

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

199 Adult Day Care
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
290 Hyperbaric Oxygen Therapy
141 Imaging
112 Nutritional Supplements and/or Services
279 Occupational Therapy Evaluation
101 Physical Therapy

997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
971 Physical Therapy Evaluation (nonpar only)

127 Speech Therapy Evaluation (nonpar only)
701 Speech Therapy
790 Occupational Therapy

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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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.