# Request for Prior Authorization

**Instructions: Use this form to request prior authorization.**
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 Prior Authorization Department at (800) 743-1655. To check the status of your request, call (800) 421-8578, (800) 628-2705 or (800) 642-4746.

## MEMBER INFORMATION

Member Name: Last First MI Date of Birth (Mo/Day/Yr)

Subscriber #

**Check appropriate box.**

Product: ☐ Healthy Families ☐ Healthy Kids ☐ Medi-Cal
Other Insurance/Policy #_____ ☐ Work-related ☐ Auto accident CCS-Eligible Condition: Yes ☐ No ☐

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

☐ Urgent for acute conditions requiring care within 72 hours or less ☐ Elective for routine, non-urgent services
☐ Notification only, for dialysis or prenatal maternity care
☐ Confidential request: Member/Provider requests confidentiality. Health Net will not mail service-confirmation letter to member.

**Designate service requested. Check appropriate box.** Anticipated date of service:_____

☐ Office procedure
☐ Outpatient service/surgery
☐ Inpatient admission
☐ Orthotics and prosthetics
☐ DME
☐ Diagnostic test
☐ Home health services
☐ Other _____

## PROVIDER INFORMATION

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

## CLINICAL INFORMATION

| ICD-9 code(s) (REQUIRED) | Diagnosis description | Date of onset/injury |
|---|---|---|
| CPT/HCPC 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-rays reports, progress notes, results of conservative treatment) | | |

| Signature of requesting physician | Date |
|---|---|

Note: Provider agrees that the results of the care or treatment rendered under this authorization shall be forwarded to the requesting physician or primary care physician named above for inclusion in the patient medical record. Provider agrees to accept Health Net or CalViva Health'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 co-insurances 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. Eligibility and benefits must be verified before rendering any medical services at www.healthnet.com.

## Determination

| Services approved | Authorization number | Valid date range of authorization | Decision date |
|---|---|---|---|
| | | | |