Health Net's Request for Prior Authorization Form

Use this form to request prior authorization for employer group Medicare Advantage (MA) HMO, HMO, PPO, Enhanced Care PPO for small business group (SBG), EPO, Point of Service (POS), and Cal MediConnect members. To avoid possible processing delays, complete all sections of the form and attach sufficient clinical information to support medical necessity for services. If you chose to print, please print legibly.
Completed forms should be faxed to **1-800-793-4473**. Health Net will provide notification of prior authorization decisions via phone, mail, fax or other means.

MEMBER INFORMATION

Member Name: Last First MI Date of birth (Month/Day/Year)

Subscriber #

Check appropriate box.

Product: ☐ HMO (POS tier 1) ☐ PPO (POS tier 2) ☐ Out-of-network (POS tier 3) ☐ EPO ☐ Medicare Advantage ☐ Cal MediConnect Other Insurance/Policy # _____ ☐ Work-related ☐ Auto accident

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

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

☐ **Expedited/urgent**: 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/expedited request** _____

☐ Notification only, for dialysis or prenatal maternity care EDC_____

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

☐ Post service request (Not applicable for Medicare Advantage plans)

Designate service requested. Check appropriate box.

☐ Office procedure
☐ Outpatient service/surgery
☐ Inpatient services
☐ Orthotics and/or prosthetics
☐ Clinical trial
☐ Other_____

Anticipated date of service: _____

☐ DME
☐ Diagnostic/advanced radiology ☐CT ☐MRI/MRA ☐PET ☐SPECT
☐ Initial outpatient rehabilitative____/Habilitative____services (PT,OT,ST)
☐ Initial home health - Is member home bound? ☐Yes ☐No
☐ Continued outpatient rehabilitative___/Habilitative___services (HH/PT/OT/ST) - Remaining authorized visits? ____ Does plan have volume limits?_____ Has member used or will use their last visit within 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 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)

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. Contracted 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 coinsurances 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 for HMO members) Do not use for FFS or PPO membership

PG 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: