OUTPATIENT CALIFORNIA HEALTH NET COMMERCIAL AUTHORIZATION FORM

Health Net

Complete and **Fax** to: 1-844-694-9165

☐ 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

*Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ Same as Requesting Provider

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

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

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) _____

422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
799 Genetic Counseling
709 Genetic Testing
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
211 OB Ultrasound
410 Observation
790 Occupational Therapy
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
101 Physical Therapy
650 Radiation Therapy
107 Respite Care
428 Second Opinion
201 Sleep Study
701 Speech Therapy
472 Stereotactic Radiosurgery
992 Transplant
724 Transportation
417 DME - Rental
120 DME - 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.

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