



OUTPATIENT CALIFORNIA HEALTH NET Complete and Fax to: 1-844-694-9165
COMMERCIAL AUTHORIZATION FORM

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.

*Date of Birth

MEMBER INFORMATION

*Medicaid/Member ID

Last Name, First

(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

Additional Procedure Code

*Start Date OR Admission Date

*Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

Additional Procedure Code

Additional Procedure Code

End Date OR Discharge Date

Total Units/Visits/Days

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

*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.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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