CalOptima Health

Received by
CalOptima Health:
Date Stamp

Retro Authorization Request for Acute Inpatient Care

Facility Name:_____ Phone:_____

Contact Name:_____ Fax:_____

Billing Service Name:_____ Provider No. (UB92 Box 51)_____

Retro Eligibility: ☐ (Member was not eligible at time of service – Retroactive eligibility now established)

Late Request: ☐ (Member was eligible at time of service – Prior Auth was not obtained)

Name:_____ Admit Date:_____ Service Begin Date:_____

CIN# Discharge Date: Service End Date:

DOB: MR/Account:

Newborn Care must indicate: Mothers SSN/CIN:_____ DOB:_____ Insurance:_____

Comments:_____

_____

_____

Attach this form to the following **Required Documents:**

☐ Admission Face Sheet
☐ Itemized Statement
☐ History & Physical Examination
If applicable
☐ Emergency Department Report
☐CCS Authorization/Denial
☐Submit evidence that member has no Medicare A benefit
(Copy of printout from Medicare common working file)

☐ Discharge Summary ☐ Coding sheet
☐ Progress Notes ☐ Physician Orders
☐ Medi-Cal Eligibility Print Out for Date of Service
☐ Operative/Procedure Report(s)
☐ Tertiary Reimbursement Documentation/DRG
☐ Primary Insurance EOB/Denial

DO NOT WRITE BELOW THIS LINE FOR CalOptima Health USE ONLY

☐ COD Eligibility ___/___/___ Start Date:_____ End Date:_____ Aid Code:_____
☐ COD Eligibility ___/___/___ Start Date:_____ End Date:_____ Aid Code:_____
☐ Health Plan_____ Start Date:_____ End Date:_____
☐ Possible CCS eligible condition – Request Authorization from and submit claim to CCS – CCS#_____

From	Through	Requested		Approved	
Date	Date	Days	Bed Type Day	Days	Bed Type

Comments:_____

_____

_____

☐ Level of care may qualify for tertiary reimbursement. Mail request for tertiary reimbursement:

- Attach DRG coding sheet or equivalent to request form.

☐ Does not meet OC EMSA P&P Trauma Triage Guidelines for Critical Trauma Victim (CTV)

Authorization Reference No.

If you disagree with this determination, you may request reconsideration of this decision by submitting an Appeal to: CalOptima Health, Attention: Grievance and Appeals Departement P.O. Box 11033, Orange, California 92856. The appeal must be in writing and: (1) be received within 60 calendar days from the date of this Care Coordination Department decision; (2) include a letter and/or document to justify reconsideration; and (3) be clearly labeled "UM Appeal."