



CalOptima Health

Processing Authorization and Modification/Change Requests From Providers

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Request to Change an Open Authorization With No Decision

- A provider may call **714-246-8686** to request a modification to an authorization request that has not yet received a decision (usually within five business days of submitting the request)
- Request will be reviewed per standard protocol and timeline
- Provider may submit a new fax indicating the modification needed, the tracking number and that it is not a duplicate request

Request to Change a Closed Authorization With a Decision

- If a provider has already received a decision on an authorization request and needs to change either the specific type of service or send it to an alternate provider:
 - An authorization request will need to be submitted via fax or the CalOptima Health Provider Portal. The request must include the reason for the request/modification, the original authorization number and that the previous authorization may be cancelled

Request to Change a Closed Authorization With a Decision (cont.)

- CalOptima Health encourages providers to submit the request via the [Provider Portal](#). Requests submitted via the portal have the potential for quicker responses, meeting auto-authorization rules and being automatically approved

Turnaround Time (TAT)

- Urgent requests are reviewed and a decision is made within 72 hours of receipt of the request
 - Urgent referrals are only to be submitted if the normal time frame for authorization will:
 - Be detrimental to the patient's life or health
 - Jeopardize patient's ability to regain maximum function
 - Result in loss of life, limb or other major bodily function
- Routine requests are reviewed and a decision made within five business days of receipt of the necessary information to make a decision, but no later than 14 calendar days from receipt of the request

Authorization Request Form

- Authorization request forms are available on the [Common Forms](https://www.caloptima.org) page of our website, www.caloptima.org
- The note and checkbox at the bottom of the form is to assist with directing the member to the appropriate provider for the service
- Allowing the member to be directed to a community/alternate provider will result in the referral being processed faster and the member being seen in a timelier manner

Authorization Request Form (cont.)



P.O. BOX 11033 ORANGE, CA 92856

Phone: (714) 246-8686

AUTHORIZATION REQUEST FORM (ARF)

ROUTINE Fax to (714) 246-8579 PHARMACY MEDICATIONS Fax to (657) 900-1649 RETRO Fax to (714) 246-8579

*** IN ORDER TO PROCESS YOUR REQUEST ARF MUST BE COMPLETED AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ Last First <input type="checkbox"/> M <input type="checkbox"/> F D.O.B. _____ Age: _____	
Mailing Address: _____ City: _____ ZIP: _____ Phone: _____	
Client Index # (CIN): _____ Name of ICF/SNF (if applicable): _____	
Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____	Provider NPI#: _____ TIN#: _____
Medi-Cal ID#: _____	Medi-Cal ID#: _____
Address: _____ Phone: _____	Address: _____ Phone: _____
Fax: _____	Fax: _____
Office Contact: _____	Office Contact: _____
Physician's Signature: _____	ICD-10: _____
Diagnosis: _____	

AUTHORIZATION REQUEST

URGENT REQUEST Fax to (714) 338-3137. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.***

Inpatient Outpatient SNF Estimated Length of Stay: _____

Date(s) of Services: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

Please check box below to indicate OK to change requested provider if required

OK to redirect to appropriate network provider. Allowing your member to be directed to a community provider will help the referral be processed faster and the member to be seen in a timelier manner.

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