Community-Based Adult Services (CBAS)

AUTHORIZATION REQUEST FORM (ARF)

☐ URGENT (72-hour process) fax to 714-481-6422 ☐ ROUTINE fax to 714-481-6423

*** 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: _____ Sex: ☐M ☐F D.O.B._____ Age: _____
Last First

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____ Preferred Language (if applicable): _____

CBAS Provider:

Provider NPI#: _____ TIN#: _____

Medi-Cal ID#: _____

Address: Phone: _____

Fax: _____

Office Contact: _____

Requestor Signature: _____

Diagnosis:

ICD-10 Code:

AUTHORIZATION REQUEST

Date(s) of Services: _____

List ALL procedures requested, along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting medical records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)
Day Services, Adult; Per Diem — Month of :		S5102	Days
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Day Services, Adult; Per Diem — Month of :		S5102	Days
Day Services, Adult; Per Diem — Month of :		S5102	Days

New Centers - those open/contracted with CalOptima Health less than two years are required to submit reauthorization requests every six (6) months

Day Services, Adult; Per Diem — Month of :	S5102	Days
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