P.O. BOX 11033 ORANGE, CA 92856 Phone: 714- 246-8686

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE ☐ RETRO Pharmacy Medications Fax 657-900-1649 OneCare Fax 714-571-2440

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

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

Patient Name: ______________________________ ☐ M ☐ F D.O.B. ____________ Age: ____________
Last First

Mailing Address: ______________________ City: ______________ ZIP: __________ Phone: ____________

Client Index # (CIN): ______________________

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: ____________ TIN#: ____________ Medi-Cal ID#: ________________	Provider NPI#: ____________ TIN#: ____________ Medi-Cal ID#: ________________
Address: Phone: ____________ Fax: ____________	Address: Phone: ____________ Fax: ____________
Office Contact: ______________________ Physician's Signature: ______________________	Office Contact: ______________________
Diagnosis: ______________________	ICD-10: ______________________

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to 714-571-2440. ***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 Facility ☐Outpatient Facility ☐ SNF:

Retro Date(s) of Service ______________________

List ALL procedures requested along with the appropriate CPT/HCPCS and Supporting Documentation

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

Revised 5/15/2022