CalOptima Health

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) ☐ **M** ☐ **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:** _____ **Fax:** _____	**Address:** **Phone:** _____ **Fax:** _____
Office Contact: _____	**Office Contact:** _____
Physician's Signature: _____	
Diagnosis: _____	**ICD-10:** _____

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.*****

☐ **CONTINUITY OF CARE (COC). Definition in accordance with the most current DHCS All Plan Letter (APL) must be present to qualify for COC. The APL includes, but is not limited to:**

1. **Member mandatorily transitioned from Medi-Cal FFS to CalOptima Health no more than 12 months prior to the submission of this request.**
2. **Member has seen OON provider at least once during the 12 months prior to the date of their initial enrollment with CalOptima Health.**

☐ **Inpatient** ☐ **Outpatient** ☐ **SNF** **Estimated Length of Stay:** _____

Dates(s) of Service: _____ **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.**