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

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: _____	
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.***

☐ 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.