EXTERNAL REQUEST FOR LETTER OF AGREEMENT

Sections 1 through 5 must be fully completed for request to be processed. If a section does not apply, insert N/A.
INCOMPLETE REQUESTS WILL BE RETURNED.

1. Responsible Contact Submitting LOA Request

Request Date:	Requestor Name/Title:
Phone:	Email:

☐ Routine Request ☐ **URGENT** Request

2. Member Information

Last Name:	First Name:	Middle Initial:
CIN #:	DOB:	
Address:		
Health Network:	Effective Date with Health Network:	

Line of Business: ☐ Medi-Cal ☐ OneCare ☐ MSSP ☐ PACE

3. Requested Provider for LOA Service

Provider Legal Name:	dba Name:	
NPI:	TIN:	
Requesting Provider/Treating Provider Name:		
Contact Name/Title:	Phone:	Email:
Service Location Address:		☐Member's Address (if DME)

Provider Type

☐ Hospital ☐ ASC ☐ LTC NF ☐ SNF (Skilled/Short Stay) Level of Care:
☐ DME ☐ NEMT ☐ Home Health ☐ Dialysis ☐Laboratory

☐ Professional (list specialty):
☐ Behavioral Health (list specialty):
☐ CalAIM Services (list service):
☐ Other(s):

4. Requested LOA Service

Authorization #:	☐ Outpatient ☐ Inpatient	Authorization Effective Date: Authorization End Date:

Transplant Type (BMT, Heart, Lung, etc.):

Transplant Care: ☐ Evaluation ☐ Pre-Care ☐ Transplant Event ☐ Post-Care Date of Transplant:

Description of Authorized Service(s) including CPT/HCPCS Codes, Description, and # of Authorized Units:

5. REQUIRED INFORMATION: *Please be concise. This section will be read by non-clinical staff. (Minimize acronym usage)

a. Brief case summary of authorized services

1. Member History (HX): _____
2. Member Current Status: _____
3. What Services are Being Requested: _____

b. Are there in-network providers with the same specialty/sub-specialty? ☐ Yes ☐ No

c. Attempted in-network redirect? ☐ Yes ☐ No
If **yes**, identify what attempts were made to redirect the member in-network: _____

Why was the in-network provider unable to render the service – Select all that apply

☐ In-network provider does not treat specified condition(s). List condition(s): _____

☐ Continuity of Care (COC) (APL 23-022[1, 2, 3, 4, 5]).
Date of last visit: _____.
All five criteria must be present to qualify for COC:

1. Member mandatorily transitioned from Medi-Cal FFS to CalOptima Health on or after January 1, 2023.
2. The member has seen OON provider at least once during the 12 months prior to the date of their initial enrolment with CalOptima Health.
3. The authorized services are covered benefits.
4. The Provider meets CalOptima Health applicable professional standards and has no disqualifying quality of care issues.
5. The Provider is a California State Plan approved Provider.

6. Provider must agree to CalOptima Health-contracted rates or Medi-Cal FFS rates.

☐ Access and Availability – Appointment time with in-network provider is greater than 30 days.

☐ Access and Availability – No in-network provider.

☐ Member requires higher level of care – In-network provider not able to treat condition(s).

If **no**, why was redirection not attempted? _____

d. What is the transition plan to bring member back into network: _____

Once LOA Request Form is completed, please send to CalOptima Health LOA Inbox.

Email: loa@caloptima.org