CalOptima Health

ICF/DD, ICF/DD-H and ICF/DD-N
Notification Form

P.O. Box 11045
Orange, CA 92856
Phone: 714-246-8600
Fax: 714-246-8843

☐ **Initial** ☐ **Re-Authorization** ☐ **Bed Hold/Leave of Absence**

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____
LOA Start Date: _____ LOA End Date: _____
LOA Start Date: _____ LOA End Date: _____
LOA Start Date: _____ LOA End Date: _____

Date of Admission: _____ **Dates of Service Requested: From:** _____ **To:** _____

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

Patient Name: _____ ☐ M ☐ F Date of Birth: _____ Age: _____

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

CIN #: _____ Aid Code: _____ County Code: _____

Facility Name: _____
Facility Address: _____
City: _____ ZIP: _____
Phone: _____ FAX: _____
Facility Provider ID #/NPI: _____
Former Facility: _____ Office Contact #: _____
Diagnosis: _____

Physician Name: _____
Physician Address: _____
City: _____ ZIP: _____
Phone: _____ FAX: _____
Physician Medi-Cal ID #: _____
Physician Signature: _____
ICD-10 Code: _____

AUTHORIZATION REQUEST

☐ **ICFDD** ☐ **4–6 Bed ICF-DDH** ☐ **7–15 Bed ICF-DDH** ☐ **4–6 Bed ICF-DDN** ☐ **7–15 Bed ICF-DDN**

SECTION II <u>Admitted From</u>:

☐ Member's home
☐ Household of another
☐ Board & Care/Assisted Living
☐ Acute hospital - Home, B&C immediately prior to acute
☐ Acute hospital - SNF/ICF immediately prior to acute
☐ Another SNF/ICF

Section III

☐ Form HS-231 Completed

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: _____ **Date:** _____