

# AUTHORIZATION REQUEST FORM

URGENT   
  ROUTINE   
  RETRO DOS \_\_\_\_\_  
 Do you have access to the portal? Yes No

UM Ambassadors: (714) 449-4923 or 855-359-6323

Facey	818-837-5712	Providence Medical Network	714-935-1431
AMG	747-229-2359	Mission	714-712-3393
Saint John's	747-229-2359	St. Joseph	714-712-3393
St. Mary's High Desert	760-683-6483	St. Jude	714-712-3393
All DME Requests		All Pharmacy Requests	
	Fax: (714) 578-8533		Fax: (714) 935-1420
Routine Commercial TAT:	5 business days	Urgent Commercial TAT:	72 Hours
Routine Senior TAT:	7 Calendar days	Urgent Senior TAT:	72 Hours
Routine Pharmacy TAT:	72 Hours	Urgent Pharmacy TAT:	24 Hours
Routine Medi-Cal TAT:	7 Calendar days	Urgent Medi-Cal TAT:	72 Hours
Routine Medi-Cal Pharmacy TAT:	24 Hours	Urgent Medi-Cal Pharmacy TAT:	24 Hours

To process your request timely, form must be complete and legible. Please include all relevant clinical documentation with the fax.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 HMO ID: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

### SERVICE REQUESTED

**Referring Provider**

**Referred to (Physician, Facility, Vendor):**

Name: _____	Name: _____
NPI#: _____	NPI#: _____
Office Contact: _____	Speciality: _____
Phone: _____	ICD10: _____ ICD10: _____ ICD10: _____
Fax: _____	<input type="radio"/> Consult <input type="radio"/> Follow-up <input type="radio"/> Outpatient <input type="radio"/> Inpatient <input type="radio"/> Second Opinion

### DME / HOME HEALTH / HOSPICE REQUESTS

**Signed orders are still required for DME & HH services**

<input type="radio"/> DME (wheelchair, CPAP, etc.): _____ Settings: _____	Patient Height: _____	Patient Weight: _____
<input type="radio"/> Home Health / Hospice: _____	Degrees: _____	Treatment Plan: _____
	Start of Care (Date): _____	End of Care (Date): _____

\*For Medication requests, please also complete the Global Prior Authorization Form

### PLEASE LIST ALL PROCEDURES ALONG WITH THE APPROPRIATE CPT / HCPS

REQUESTED PROCEDURES:	CPTS / HCPC CODES:	QUANTITY / UNITS (REQUIRED):	MODIFIERS:

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_