PRIMARY HEALTH CARE
MEDICAL GROUP IPA

Treatment Authorization Request Form Fax completed form to 888-308-0992

***Please note*:** *Incomplete request form with no supporting notes will be returned without being processed. Determination Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the requested provider.*

Type of Request: *circle one* **ROUTINE** **URGENT** *(medical condition that requires **immediate** intervention)* **RETRO**

MEMBER INFORMATION **Date:**

Patient Name: _____ Gender: M / F Date of Birth:_____

Patient's Address: _____
Street City Zip

Phone: _____ Health Plan: _____ Subscriber Name: _____

Subscriber # _____ Member's Primary Care Provider: _____

REQUESTING PROVIDER	REQUESTED PROVIDER & FACILITY
Name:	Name: NPI#:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Specialty / Facility Type:
Today's Date:	Place of Service:

REQUESTED SERVICES AND MEDICAL NECESSITY

Diagnosis Description(s):

ICD10(s):_____

Reason for Referral: _____

Information to support requested service: (please attached clinical notes) _____

_____

Requested Service(s):

Description : _____ CPT: _____ Quantity : _____

Description : _____ CPT: _____ Quantity : _____

Description : _____ CPT: _____ Quantity : _____

Description : _____ CPT: _____ Quantity : _____

FOR OFFICE USE ONLY:

Reviewed and Approved By: _____ **Date:** _____

AUTHORIZATION #: _____ **Notes:** _____

****For Non-Contracted or LOA Providers, Please provide/attach your Form W-9 with your Bill/Claim forms****

- Approved Authorizations are effective from the date they are Approved and expire three (3) months from the effective date and are based on the Member's [ ] Eligibility at the time the authorization is Approved, and on the Date Services are rendered.
- Providers must verify member eligibility to ensure coverage and payment.
- Claims for services rendered without required prior authorization may be denied reimbursement.
- Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to **Primary Healthcare Medical Group IPA - UM Dept fax at 888-308-0992**. For any questions, please call our **UM Department at 800-698-6151.**
- **Mailing Address: Primary Healthcare Medical Group-IPA, 1520 Nutmeg Place, Suite 210, Costa Mesa CA 92626**
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety code §1370, and California Evidence Code §1157.

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