

Direct: 1-855-754-7271

FAX: 1-800-801-1200 and FAX: 650-375-5820

PLEASE PRINT CLEARLY - MUST ATTACH MEDICAL RECORDS IN ORDER TO PROCESS REQUEST

Date of Request:

Routine (3-5 business days)

Urgent (24 hours)

Use only when following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Member Information

Plan Name: CALIFORNIA IRONWORKERS

Subscriber Name: D.O.B: ID Number: Patient's Name: D.O.B:

****PLEASE ATTACH COPY OF MEDICAL CARD****

Address: City: State: Zip:

Phone# of Subscriber: Medicare Primary: Yes No Other Insurance: Yes No

Requesting Physician Information

Requesting Physician: Phone: Fax:

Address: City: State: Zip:

Tax Identification # Referring Physician Signature: Date:

M.D. Office Contact (office person requesting auth.):

Contracting with ANTHEM BLUE CROSS: YES NO

Contracting with FIRST HEALTH: YES NO

*Diagnosis: *ICD-9:

*Service(s) Being Requested

*CPT Codes:

* Items MUST be completed

Authorization Request

Referring to: Tax ID: Specialty:

Address City: State: Zip: Phone:

Number of Visits Requested: Duration: Expected Date of Service: FAX:

Facility/ Hospital Name/Surgery Center: TAX ID #:

Contracting with ANTHEM BLUE CROSS: YES NO

Contracting with FIRST HEALTH: YES NO

Address City: State: Zip: Phone: FACILITY FAX:

Office Inpatient Services Outpatient Services 23 Hour Short Stay

Describe symptoms, duration, tried and/or failed treatment, relevant lab, diagnostic test (if possible please fax in supporting documentation with request):

PHA USE ONLY

Approved # of Visits: Interqual Guidelines Met #

Authorization Number: Valid From: to Expirations Date

Denied Denial Reason:

Other

Medical Director Signature

Case Manager/ Care Counselor Signature

Date

Authorization is subject to eligibility and benefits on date of service. To ensure proper payment for services rendered, please verify eligibility on date of service. If member is determined to be ineligible on date of service, he/she may be responsible for payment of these services. Please contact the number listed on the patient card to verify eligibility.

Please send all claims to the address listed on the patient ID card