PACIFIC HEALTH ALLIANCE Medical Prior Authorization Request Form

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