AltaMed

QUALITY CARE WITHOUT EXCEPTION™

ALTAMED AUTHORIZATION REQUEST FORM

☐ **URGENT (72 HOURS)** Requests submitted as an urgent referral when standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

☐ **ROUTINE (5 BUSINESS DAYS)**

REQUEST DATE: _____

SUBMIT AUTHORIZATION REQUEST VIA FAX TO (323)720-5608

PATIENT INFORMATION

Patient Name: **DOB:**

Health Plan: **Health Plan ID:**

AUTHORIZATION REQUEST INFORMATION

REQUESTED PROVIDER:

Provider Name:

Provider Specialty:

SERVICES REQUESTED:

CPT Code:	CPT Code Description:	ICD-9 Code:	ICD-9 Code Description:	Ambulatory Surgery Center/Hospital Name:	Place of Service: -Office -Outpatient -Inpatient

TREATMENT AND WORK-UP DONE WITH RESULTS:

ATTACHMENTS: ☐ **Progress Notes** ☐ **Laboratory & Radiology Findings** ☐ **Medication List** ☐ **Other**

Referring Physician Name: _____

Referring Physician Address: _____

Referring Physician Phone: _____ **Referring Physician Fax:** _____

Office Contact Name: _____

Primary Care Physician (*If different than referring Provider):*_____

** For Inquiries or questions on authorization status or in general call the AltaMed Customer Service Department at: (866) 880-7805. All items listed within the Authorization Request form are required for submission to the Medical Management Department. Authorization Request forms will not be accepted if illegible and/or incomplete**