# 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***