AUTHORIZATION REQUEST FORM

Request Date: _____

☐ **AltaMed Health Services** ☐ **Omnicare Medical Group** ☐ **Family Choice Medical Group** ☐ **Golden Physicians Medical Group**

☐ **Medi-Cal** ☐ **Commercial*** ☐ **Medicare**

☐ **ROUTINE (7 Calendar Days/*5 Business Days)**

☐ **URGENT (72 Hours)** *Applicable when standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.*

☐ **RETRO (30 Calendar Days)** *Submitted within 30 calendar days from date of service*

Retro Date of Service: _____

☐ **Continuity of Care** *Last Visit Date:* _____ ☐ **Standing Referral** ☐ **Second Opinion**

☐ **Member has a terminal illness, and services are considered experimental and/or investigational.**

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

For inquiries or questions on authorization status, or in general, call the Altura Customer Services Department at (323) 417-7741

PATIENT INFORMATION

Patients Name: _____ **DOB:** _____

Health Plan: _____ **Health Plan ID:** _____

AUTHORIZATION REQUEST INFORMATION

ICD-10: _____ **Diagnosis Description:** _____

CPT Code: _____ **CPT Qty:** _____ **CPT Description:** _____

Referred To Provider Name: _____ **Specialty:** _____

Facility: _____ **Place of Service (POS):** _____

Address: _____

Telephone: _____ **NPI/Tax ID:** _____

Reason for referral: _____

Attachments:

☐ **Clinical** ☐ **Laboratory & Radiology Findings** ☐ **Medication List** ☐ **Other**

Requesting Provider Name: _____

Address: _____

Telephone: _____ **Fax:** _____

Primary Care Provider *(If different than Requesting Provider)*: _____

Requesting Provider Signature: _____

For Home Health requests, in addition to the above section, please complete the following page.

Altura Management Services

AUTHORIZATION REQUEST FORM

Request Date: _____

HOME HEALTH SERVICES

Initial Start of Care (SOC): _____ **Last Visit Date:** _____

Service Request	CPT Codes	Start Date	End Date	# of Visits	Frequency (# of Visits per Week)
RN					
PT					
OT					
ST					
HHA					
MSW					
Other					

For Internal Use Only: