Authorization Form

Health Plan of San Joaquin | Mountain Valley Health Plan

Please check Line of Business:	☐ Medi-Cal	☐ Inpatient _____ days ☐ Outpatient	☐ Office Visit ☐ Other: _____

Service requiring Health Plan approval must be submitted on this form.
Payment is subject to member eligibility and medical necessity determination.
Please confirm eligibility by calling (209) 942-6320 or IVR (209) 942-6303.
Fax this authorization and supporting documents to Health Plan's UM Department.

Inpatient Fax
209-762-4702
Outpatient Fax
209-942-6302

Please fill-in all requested information for timely processing of your request.

Completed by: _____

☐ **Routine** ☐ **Urgent**	☐ **Retrospective Review**	☐ **PCP**	☐ **Specialist**

PATIENT		**REQUESTING PROVIDER**	**NPI:**	**TIN:**
Name: *Last, First*		**Name:**		
Health Plan Member ID#:		**Address:**		
Date of Birth: *MM/DD/YY*	**Sex:** ☐ Male ☐ Female	**City, State, ZIP:**		
Appointment Date:		**Phone:**	**Fax:**	

AUTHORIZE TO (Service Provider)			
Provider (Practitioner):		**Group/Pay To/Facility:**	
Specialty:		**Phone:**	**Fax:**
Address:		**City, State, ZIP:**	
REQUIRED INFORMATION FOR SERVICE PROVIDERS:	**Provider NPI:**	**Tax ID:**	**Facility/ Group NPI:**
Comments:			

REASON FOR AUTHORIZATION REQUEST: Please indicate the quantity ( ) you are requesting for each CPT/HCPS code. If no quantity indicated, the default amount will be "1".

ICD-10					
Some ICD-10 codes are reported to their highest number of characters available (3, 4, 5, 6, or 7). Please document diagnosis completely.					
CPT/HCPCS Code (Quantity)	( )	( )	( )	( )	( )
Modifier Required for DME					

Requesting Provider Signature: _____ **Date:** _____