

390 Hospice Services

211 OB Ultrasound

290 Hyberbaric Oxygen Therapy

395 Infertility Diagnosis or Treatment

OUTPATIENT CALIFORNIA HEALTHNET COMMERCIAL AUTHORIZATION FORM

Complete and Fax to: 1-844-694-9165 Transplant **Fax** to: 1-833-769-1142

HMO

Request for additional	units. Exis	isting Authorization		Units	POS	
Standard requests -	Determinatio	on within 5 business d	ays of receiving all	necessary information.	PPC	
				to treat an injury, illness or condition (not li	ife threatening) within	
Urgent requests - 7	d complications and u	ations and unnecessary suffering or severe pain. URGENT REQUESTS MUST BE SIGNED BY THE				
* INDICATES REQUIRED I	FIELD	X		REQUESTING PHYSICIAL		
ATMPED INCODMA		ast Name, First		*Date of Birth		
MEMBER INFORMA	IIUN					
Member ID				(MMDDYYYY)		
PEQUESTING DROV	"DED INEOE	PMATION Reques	sting Provider Contact	rt Name	N TO RECEIVE PRIORITY.	
REQUESTING PROV	IDER INFOR					
Requesting NPI		*Requesting T	IN	Phone	_	
Requesting Provide <i>r Addre</i> ss	3			*Fax		
City, State, Zip						
σιιγ, στατο, Στρ						
SERVICING PROVID	ER / FACILI	TY INFORMATIO	N			
Same as Reques	sting Provider	Servicing Provider Cont	tact Name -			
*Servicing NPI		*Servicing TII	N -	Phone		
-						
Servicing Provider/Facility N	iame Address				Fax	
ty, State, Zip						
AUTHORIZATION REQU	EST					
*Primary Procedure Coc	de	Additional Proced	ure Code	*Start Date OR Admission Date	*Diagnosis Code	
					-	
(CPT/HCPCS)	(Modifier	(CPT/HCPCS)	(Modifier	(MMDDYYYY)	(ICD-10)	
Additional Procedure Code		Additional Proced		End Date OR Discharge Date	Total Units/Visits/Days	
710010101010101010101010101010101010101	,	Additional Floced	Tile Code	Life Pate on Sisting Sate		
(CPT/HCPCS)	(Modifier	(CPT/HCPCS)	(Modifier	(MMDDYYYY)		
			/Enter the	Carrian tune number in the hovee)		
*OUTPATIENT SE	RVICE TYPE	E 410 Obser	,	Service type number in the boxes) Behavioral Health		
412 Auditory	410 Observation		533 BH Applied Behavioral Analysis	DME		
422 Biopharmacy		210 Orthot	tics 5	312 BH Community Based Services		
712 Cochlear Implants & Surgery 299 Drug Testing				515 BH Electroconvulsive Therapy	417 Rental	
922 Experimental and Investigational Services		viooo '	0 ,	516 BH Intensive Outpatient Therapy	120 Purchase	
205 Genetic Testing & Counseling		202 Pain M 147 Prosth		510 BH Medical Management 518 BH Mental Health /Chemical Dependen	ncy Observation	
249 Home Health		428 Second		519 BH Outpatient Therapy	(Purchase Price)	

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

993 Transplant Evaluation 520 BH Professional Fees

530 BH PHP

522 BH Psychiatric Evaluation

521 BH Psychological Testing

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION. **Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. Health Net of California, Inc., Health Net Community Solutions, inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

428 Second Opinion

724 Transportation

209 Transplant Surgery

201 Sleep Study

Outpatient Authorization Supplemental Form

This page is optional and meant to be used when an authorization request exceeds more than four (4) Procedure Codes. When applicable, please submit this form with the Outpatient Prior Authorization Form to the applicable fax number.

* INDICATES REQUIRED FIELD			
MEMBER INFORMATION	*Date of Birth (MMDDYYYY)		
* Medicaid/Member ID	Las	st Name, First	
AUTHORIZATION REQUEST			
*Additional Procedure Code	*Start Date OR Admission Date	*End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days
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Additional Procedure Code	Start Date OR Admission Date	End Date	Total Units/Visits/Days

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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