#### **PROVIDER***Update* Health Net<sup>®</sup> CONTRACTUAL **SEPTEMBER 25, 2018 UPDATE 18-689 3 PAGES** THIS UPDATE APPLIES TO **Corrected Individual Family Plan Prior CALIFORNIA PROVIDERS:** Physicians Authorization Request Forms Participating Physician Groups Hospitals Health Net of California, Inc. and Health Net Life Insurance Company's (Health Net's) Ancillary Providers Individual Family Plan (IFP) Outpatient California Health Net Commercial Authorization LINES OF BUSINESS: Form and Inpatient California Health Net Commercial Authorization Form have been • HMO/POS/HSP corrected to indicate the standard requests determination time frame is within five business days and not five calendar days as previously indicated. • EPO $^{\odot}$ Medicare Advantage (HMO) CORRECT $^{\bigcirc}$ Medi-Cal Determination withi (5 business days ) receiving all necessary information. Standard requests -○ Kern ○ Los Angeles INCORRECT ○ Molina ○ Riverside Determination within 5 cale receiving all necessary information. Standard requests -○ Sacramento $^{\bigcirc}$ San Bernardino ○ San Diego Corrected forms are attached for reference and are also available online through the ○ San Joaquin

Corrected forms are attached for reference and are also available online through the Forms section of the Provider Library on the Health Net provider portal. To access the Forms section, select:

- 1. provider.healthnetcalifornia.com.
- 2. Resources.
- 3. Contractual.
- 4. Go to the Provider Library.
- 5. Forms.
- 6. Outpatient California Health Net Commercial Authorization Form or Inpatient California Health Net Commercial Authorization Form as applicable

## ADDITIONAL INFORMATION

If you have questions regarding the prior authorization request forms for IFP, contact the Health Net Medical Management Department at 1-800-977-7282.

For all other questions, contact the Health Net Provider Services Center by email at provider\_services@healthnet.com within 60 days, by telephone or through the Health Net provider website as listed in the right-hand column.

#### PROVIDER SERVICES provider\_services@healthnet.com

## EnhancedCare PPO (IFP)

○ Stanislaus

○ Tulare

1-844-463-8188 provider.healthnetcalifornia.com IFP – Community Care HMO, PPO, PureCare HSP, PureCare One EPO 1-888-926-2164 provider.healthnetcalifornia.com

### PROVIDER COMMUNICATIONS

provider.communications@ healthnet.com fax 1-800-937-6086

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## INPATIENT CALIFORNIA HEALTH NET COMMERCIAL PRIOR AUTHORIZATION

Standard requests - Determination within 5 business days of receiving all necessary information.

**Urgent requests** - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

Х				QUESTS MUST BE SIGN TO RECEIVE PRIORITY		_		
*Indicates Re	quired Field							
MEMBER INFO	RMATION			*Date of Birth				
*Medicaid/Member ID			Last N		(MMDDYYYY)			
REQUESTING F	PROVIDER INF	ORMATION						
*Requesting NPI		*Reques	*Requesting TIN		Requesting Provider Contact Name			
Requesting Provider Name		Phor		ne *Fax				
1	OVIDER / FAC Requesting Provic	CILITY INFORMA	TION					
*Servicing NPI	ervicing NPI *Servicing TI		ng TIN	IN Servicing Provider Contact Name				
Servicing Provider/Facility Name			Phone		Fax			
AUTHORIZATIO	-							
*Primary Procedur	e Code	Additional Proce	edure Code	* <b>Start Date</b> OR A	dmission Date	*Diagnosis Code		
(CPT/HCPCS)	(Modifier)	(CPT/HCPCS)	(Modifier)	(MMDDYYYY)		(ICD-10)		
Additional Procedure Code		Additional Procedure Code		<b>Discharge Date (if applicable)</b> otherwise Length of Stay will be based on Medical Necessity		Additional Diagnosis Code		
(CPT/HCPCS)	(Modifier)	(CPT/HCPCS)	(Modifier)	(MMDDYYYY)		(ICD-10)		
*INPATIENT SE	ERVICE TYPE	(Ente	r the Service type	number in the boxe	s)			
<ul> <li>490 Boarder Baby</li> <li>220 Comprehensive Inpatient Rehab Facility</li> <li>779 C-Section</li> <li>479 Inpatient Rehab Hospital</li> <li>121 Long Term Acute Care</li> <li>970 Medical</li> <li>300 Neonate</li> </ul>			402 Skilled N 492 Sub Acute 411 Surgical 209 Transplar	<ul> <li>414 Premature/False Labor</li> <li>402 Skilled Nursing Facility</li> <li>492 Sub Acute</li> <li>411 Surgical</li> <li>209 Transplant Surgery</li> <li>720 Vaginal Delivery</li> </ul>				
		ALL REQUIRED F	IELDS MUST BE FILLE	D IN AS INCOMPLETE I	FORMS WILL BE REJECTED.			
COPIES	OF ALL SUPPORTIN				NFORMATION MAY RESULT IN DE	LAYED DETERMINATION.		

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# **OUTPATIENT CALIFORNIA HEALTH NET** Complete and Fax to: 1-844-694-9165 COMMERCIAL AUTHORIZATION FORM

Request for additional units.	Existing Authorization		Units				
Standard requests - Det	ermination within 5 <b>business</b> d	ays of receiving all neo	cessary information.				
	y this request is urgent and me to avoid complications and uni						
* INDICATES REQUIRED FIELD	X	X         URGENT REQUESTS MUST BE SIGNED BY THE           X         REQUESTING PHYSICIAN TO RECEIVE PRIORITY.					
MEMBER INFORMATION	1		*Date of Birth				
Medicaid/Member ID		Last Name, First (MMDDYYYY)					
REQUESTING PROVIDER	RINFORMATION			IAN TO RECEIVE PRIORITY.			
Requesting NPI	*Requesting T	IN	Requesting Provider Contact Name				
Requesting Provider Name		Phone		*Fax			
SERVICING PROVIDER / Same as Requesting Pr	FACILITY INFORMATIC	N					
Servicing NPI	*Servicing TIN	١	Servicing Provider Contact Name				
Servicing Provider/Facility Name		Phone	Fax				
AUTHORIZATION REQU	EST						
*Primary Procedure Code	Additional Proced	ure Code	*Start Date OR Admission Date	*Diagnosis Code			
(CPT/HCPCS) (Modifie	er) (CPT/HCPCS)	(Modifier)	(MMDDYYYY)	(ICD-10)			
Additional Procedure Code	Additional Proced	ure Code	End Date OR Discharge Date	Total Units/Visits/Days			
(CPT/HCPCS) (Modifie	er) (CPT/HCPCS)	(Modifier)	(MMDDYYYY)				
<b>*OUTPATIENT SERVIC</b>	ETYPE (Ente	er the Service type n	umber in the boxes)				
<ul> <li>422 Biopharmacy</li> <li>712 Cochlear Implant</li> <li>299 Drug Testing</li> <li>922 Experimental and</li> <li>799 Genetic Counseli</li> <li>709 Genetic Testing</li> <li>249 Home Health</li> <li>390 Hospice Services</li> <li>290 Hyperbaric Oxyg</li> <li>211 OB Ultrasound</li> <li>410 Observation</li> <li>790 Occupational The</li> </ul>	d Investigational Services ng en Therapy	<ul> <li>997 Office Visit/Co</li> <li>794 Outpatient Ser</li> <li>171 Outpatient Sur</li> <li>202 Pain Managem</li> <li>101 Physical Therap</li> <li>650 Radiation Ther</li> <li>107 Respite Care</li> <li>428 Second Opinio</li> <li>201 Sleep Study</li> <li>701 Speech Therap</li> <li>472 Stereotactic R</li> <li>992 Transplant</li> <li>724 Transportation</li> </ul>	rvices rgery ent 417 DM py 120 DM rapy n n	E - Rental E - Purchase Price)			

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

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