

112 Nutritional Supplements and/or Services

279 Occupational Therapy Evaluation -

101 Physical Therapy

OUTPATIENT CALIFORNIA HEALTHNET Complete and Fax to: 1-800-743-1655 **MEDI-CAL AUTHORIZATION FORM**

Transplant Fax to: 1-833-769-1141

Request for addit	tional units. Existin	g Authorization	Units			
Standard requ	ests - Determination w	rithin 5 business days of receiving	all necessary information.			
·	I certify this reques	t is urgent and medically necessa	ry to treat an injury, illness or condition (not life th	reatening) within		
Urgent request	ts - 72 hours to avoid co	omplications and unnecessary sur	ffering or severe pain. URGENT REQUESTS MUST B	E SIGNED BY THE		
* INDICATES REQUI	IRED FIELD	Χ	REQUESTING PHYSICIAN TO	RECEIVE PRIORITY.		
Last Name, First			*Date of Birth	*Date of Birth		
MEMBER INFO	RMATION					
Member ID			REQUESTING PHYSICIAN TO RECEIVE PRIORITY. *Date of Birth (MMDDYYYY) Contact Name			
RECHIESTING D	ROVIDER INFORM	ATION Requesting Provider Con	ntact Name			
Requesting NPI	NOVIDEN IN ONI	*Requesting TIN				
toquosting (VI)		nequesting Till	Phone			
Requesting Provide <i>r Ac</i>	ddress		*Fax			
equesting i rovider ric	247033		Tux			
City, State, Zip						
ERVICING PRO	OVIDER / FACILITY	INFORMATION				
	-	rvicing Provider Contact Name				
*Servicing NPI		*Servicing TIN	Phone			
corrolling						
Servicing Provider/Fac	ility Name Address			Fax		
ty, State, Zip						
AUTHORIZATION R	PEOLIEST					
	•		*Chart Data OD Adminsion Data	*Diagnosia Codo		
*Primary Procedur	e Code	Additional Procedure Code	*Start Date OR Admission Date	*Diagnosis Code		
(CPT/HCPCS)	(Modifier	(CPT/HCPCS) (Modifier	(MMDDYYYY)	(ICD-10)		
Additional Procedure		Additional Procedure Code	End Date OR Discharge Date	Total Units/Visits/Days		
		That is the second of the second				
(CPT/HCPCS)	(Modifier	(CPT/HCPCS) (Modifier	r (MMDDYYYY)			
		(Enter t	the Service type number in the boxes)			
*OUTPATIEN	T SERVICE TYPE	997 Office Visit/Consult	the dervice type namber in the boxesy			
199 Adult Day Care 794 Outpatient Services 127 Sp			127 Speech Therapy Evaluation (nonpar only)			
710 Cooklass Issues of Constant		701 Speech Therapy				
299 Drug Testing	a a ourgory	428 Second Opinion 201 Sleep Study	790 Occupational Therapy			
922 Experimental	and Investigational Services	993 Transplant Evaluation) pur			
205 Genetic Testing & Counseling		209 Transplant Surgery	DME			
290 Hyperbaric Oxygen Therapy -		724 Transportation	417 Rental			
141 Imaging		971 Physical Therapy	120 Purchase			

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED. COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

(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 Health Plan Benefit and medically necessary with prior authorization as per 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.

Evaluation (nonpar only)

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	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				
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				

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