



OUTPATIENT CALIFORNIA HEALTHNET
MEDI-CAL AUTHORIZATION FORM

Complete and Fax to: 1-800-743-1655
Transplant Fax to: 1-833-769-1141

Request for additional units. Existing Authorization Units

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

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

* INDICATES REQUIRED FIELD

X

URGENT REQUESTS MUST BE SIGNED BY THE
REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

Last Name, First

*Date of Birth

MEMBER INFORMATION

*Member ID

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider Address

*Fax

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing Provider Contact Name

*Servicing NPI

*Servicing TIN

Phone

Servicing Provider/Facility Name Address

Fax

City, State, Zip

AUTHORIZATION REQUEST

*Primary Procedure Code

Additional Procedure Code

*Start Date OR Admission Date

*Diagnosis Code

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(ICD-10)

Additional Procedure Code

Additional Procedure Code

End Date OR Discharge Date

Total Units/Visits/Days

(CPT/HCPCS)

(Modifier)

(CPT/HCPCS)

(Modifier)

(MMDDYYYY)

(Enter the Service type number in the boxes)

*OUTPATIENT SERVICE TYPE

- 199 Adult Day Care
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
290 Hyperbaric Oxygen Therapy -
141 Imaging
112 Nutritional Supplements and/or Services
279 Occupational Therapy Evaluation -
101 Physical Therapy

- 997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
971 Physical Therapy
Evaluation (nonpar only)
127 Speech Therapy Evaluation (nonpar only)
701 Speech Therapy
790 Occupational Therapy
DME
417 Rental
120 Purchase

(Purchase Price)

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.

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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