Premier Patient Care IPA Treatment Authorization Request Form
Fax completed form to 888-972-1931

Please note: *Incomplete request form without supporting clinical notes will delay the determination process. Determination Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the requested provider.*

Type of Request: *circle one* **ROUTINE URGENT** ***(medical condition that requires immediate intervention only)*** **RETRO**

MEMBER INFORMATION **Date:**

Patient Name:______________________________ Gender: M / F Date of Birth:__________

Patient's Address:____
Street City Zip

Phone:__________ Health Plan: __________

Subscriber Name:__________ Subscriber #_____

Member's Primary Care Provider: __________

REQUESTING PROVIDER	REQUESTED PROVIDER & FACILITY
Name:	Name:
Type of Specialty:	Type of Specialty:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Non-Contracted Providers only):
Today's Date:	Place of Service:

REQUESTED SERVICES AND MEDICAL NECESSITY

Diagnosis Description(s):__________

ICD10(s):__________

Reason for Referral: __________

Information to support requested service: (please attached relevant clinical notes, physical exam, labs, test results)________

____

Requested Service(s): Description:__________ CPT:__________ # Units__________
Description:__________ CPT:__________ # Units__________
Description:__________ CPT:__________ # Units__________
Description:__________ CPT:__________ # Units__________

- Approved authorizations are effective from the date they are received and expire two (2) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed.
- Providers must verify member eligibility to ensure coverage. Approved Authorization is not a guarantee of payment.
- Claims for services rendered without required prior authorization may be denied reimbursement.
- Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to Premier Patient Care IPA- UM Dept at fax at 855-405-2288. For any questions, please call our **UM Department at (657)-206-8700.**
  This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety code §1370, and California Evidence Code §1157.

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