



FAX ALL AUTH REQUESTS TO (209) 572-6909

# Request for Authorization

## Instructions for Use

1. Complete form. All fields are required to be completed. Forms submitted without this information will be returned for additional information.
2. Attach medical records e.g. chart notes, imaging/procedure reports, etc.
3. For authorization statuses call AllCare Customer Service at (209) 458-5400.

Date: \_\_\_\_\_ Type of Request:  Routine  Retro  Medically Urgent (Allow up to 72 hours for processing)  
Date: \_\_\_\_\_

Referrals Used

**NOTE: Within 2 days before the actual date of service, Provider MUST confirm with the member's health plan that coverage is still in effect.** AllCare and/or the health plan reserve the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

<b>Member Name:</b>		<b>DOB:</b>	
<b>Health Plan:</b>		<b>Health Plan ID#:</b>	
<b>PCP:</b>		<b>Requesting Provider:</b>	
<b>Contact Person:</b>		<b>Phone:</b>	<b>Fax:</b>
<b>Requested Provider:</b>			
<b>Date of Requested Service (enter pending if not scheduled):</b>		<b>Assistant Surgeon (if necessary):</b>	
<b>Requested Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		<b>Facility Name:</b>	
<b>Diagnosis Code(s) (include all that apply):</b>			

CPT / HCPC Code	Quantity	Procedure Description

**Additional Comments:**

This fax is intended only for the use of the addressee and may contain information that is privileged or confidential and is exempt from disclosure under applicable law. This includes, but is not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the privacy regulations of the Department of Health and Human Services. If you received this fax in error please notify us immediately by telephone at (209) 550-5200.