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 authorizations statuses call **AllCare Customer Service at (209) 458-5400.**

Date: _____ **Type of Request:** ☐ **Routine** ☐ **Retro Date: _____** ☐ **Medically Urgent (Allow up to 72 hours for processing)**

☐ **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.*

Member Name:	**DOB:**	
Health Plan:	**Health Plan ID#:**	
PCP:	**Requesting Provider:**	
Contact Person:	**Phone:**	**Fax:**
Requested Provider:		
Date of Requested Service (enter pending if not scheduled):	**Assistant Surgeon (if necessary):**	
Requested Place of Service: ☐ **Office** ☐ **Inpatient** ☐ **Outpatient**	**Facility Name:**	
Diagnosis Code(s) (include all that apply):		

CPT / HCPC Code	Quantity	Procedure Description

Additional Comments: