NOTE: Do not use a cover sheet. This form should be the FIRST page of your fax.

CLEAR FORM

HealthPlan OF SAN MATEO

Prior Authorization Request Form

Fax completed form to 650-829-2079.

Please type into PDF form and fill out all fields.

REQUEST	LINE OF BUSINESS
☐ URGENT	☐ CAREADVANTAGE
☑ ROUTINE	☑ MEDI-CAL
Mark ✓ or X	☐ ACE
	☐ HEALTHWORX

Today's Date: 11-06-2024 MM-DD-YYYY

Is member currently in the hospital? ☐ YES ☑ NO **IF YES, FAX Facesheet to 650-829-2060**

➢ **Member Last Name:** Denver **First Name, M.I.:** John

Street Address: 123 East St. **City, State, ZIP:** San Mateo, CA 94401

Phone: (650) 123-4567 **Member ID#:** 123456789 **DOB:** 01-01-2020 **Age:** 4

➢ **Requesting Provider:** ABC Therapy Group **NPI:** 9876543210

Street Address: 321 West St. **City, State, ZIP:** San Mateo, CA 94401

Phone: (650) 987-6543 **Fax:** (650) 444-4444 **Office Contact:** James Dean

➢ **Servicing Provider** (if needed): _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Primary Diagnosis Code: Code **Description:** Diagnosis Code Description

Line No.	Procedure Code (CPT/HCPCS Code/Modifier if applicable)	Specific Services Requested	Units of Service (Days/Quantity)
1	Code	Code description here	Number of units
2			
3			
4			
5		See HPSM's Prior Authorization Required List	
6		for service descriptions.	
7			
8			
9			
10			

Requested Service Dates FROM: 11-10-2024 MM-DD-YYYY **TO:** 05-10-2024 MM-DD-YYYY

Optional comments for medical justification. Requesting Provider please attach required medical records/supporting documents.

Please see attached clinical information.

INPATIENT ONLY – LTC Required Information (*Mark ✓ or X*):

☐ Transfer ☐ Initial ☐ Reauthorization ☐ Bed Hold ☐ Skilled Nursing ☐ ICF-DD ☐ Sub-Acute

To the best of my knowledge, the above information is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Signature of Physician or Provider **Title** **Date** MM-DD-YYYY

801 Gateway Blvd., Suite 100, South San Francisco, CA 94080 · TEL: **650-616-0050** · TTY: **1-800-735-2929**
For authorization questions contact HPSM Health Services Ph **650-616-2070** · Fax **650-829-2079** · For Facesheets fax to 650-829-2060

PRINT FORM

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE ID CARD IS CURRENT BEFORE RENDERING SERVICE.

Version 5.0 January 2023

Request (URGENT/ROUTINE)
Most requests should be marked ROUTINE and will be processed in five (5) days. URGENT should only be used when turnaround time can cause serious harm to member's life and health.

Requesting Provider
This section is required and should be completed using provider group NPI, not an individual NPI.

Servicing Provider
This section can include information on the individual who will be providing the service.

Units of Service
Include in total units over six (6) month span. Do not submit hours or units/week. This is total units/authorization period.

Requested Service Dates
Authorization period should be no longer than six (6) months. Reauthorization periods must be every six (6) months.

Inpatient Only
This field is only to be used by long-term care and in-patient facilities. If an ABA member is in a 24 hour care setting, they will not qualify for ABA services.