

Pre-Authorization Request Form



Fax: (415) 357-1292

Telephone: (415) 547-7818 ext.7080

NOTE: All fields marked with an asterisk (*) are required.

Select all that apply: New Request Modification Request for Authorization #: Second Opinion

Select type of request*: Urgent Routine Retro (Must be submitted within 30 calendar days of date of service)

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Please verify eligibility using one of the following methods:

1. Web: **www.sfhp.org/providers**
2. Interactive Voice Response: **(415) 547-7810**
3. SFHP Customer Services: **(800) 288-5555**

Select line of business: Medi-Cal Healthy Kids Healthy Workers

Does additional coverage exist?* Yes No If yes, specify the following: Carrier Policy#

PATIENT			REQUESTING PROVIDER		
Name*:			<input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Specialist <input type="checkbox"/> Vendor/Ancillary		
SFHP ID#:	Date of Birth*:		Name*:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:			Telephone*:		
Telephone:			Contact Name:		Fax:
Address:			Address:		
City: State: Zip:			City: State: Zip:		

RENDERING PROVIDER		
Name / Facility / Vendor*:		<input type="checkbox"/> Out of Member's Medical Group <input type="checkbox"/> Non-Contracted
Specialty*:	NPI#:	Reason for out of medical group/non-contracted provider:
Telephone*:		
Contact Name:	Fax*:	
Address:		
City: State: Zip:		

DIAGNOSES / SERVICE CODES

At least one valid diagnosis code **and** one valid service code are required.*

Diagnosis Codes Please document diagnosis completely.

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Service Codes Indicate quantity and modifiers (if applicable) for each code. If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS values.

Code	Mod	Qty	Description	Code	Mod	Qty	Description

Select hospital status*: Inpatient, number of days: Outpatient **Date of Service:**
Comments: **Today's Date:**

Important: Please attach appropriate clinical documentation to support your request.