AltaMed

QUALITY CARE WITHOUT EXCEPTION™

ALTAMED AUTHORIZATION REQUEST FORM

☐ **URGENT (72 HOURS)** Requests submitted as an urgent referral when standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

☐ **ROUTINE (5 BUSINESS DAYS)**

For Inquiries or questions on authorization status or in general call the AltaMed Customer Service Department at: (866) 880-7805.

SUBMIT AUTHORIZATION REQUEST VIA FAX TO (323)720-5608

REQUEST DATE: _____

PATIENT INFORMATION

Patients Name: _____

DOB: _____

Health Plan: _____ **Health Plan ID:** _____

AUTHORIZATION REQUEST INFORMATION

DIAGNOSIS: _____ **ICD-9:** _____

REQUESTED SPECIALTY/PROVIDER: _____

REASON FOR REFERRAL:

_____

_____

CPT Code: _____ **CPT Description:** _____

_____ _____

_____ _____

TREATMENT AND WORK-UP DONE WITH RESULTS:

_____

_____

ATTACHMENTS:

☐ **Clinicals** ☐ **Laboratory & Radiology Findings** ☐ **Medication List** ☐ **Other**

_____ _____

(Referring Physician's Signature) **(Print Physician's Name)**

Referring Physician Address: _____

Referring Physician Phone: _____ **Referring Physician Fax:** _____

Office Contact Name: _____

Primary Care Physician (*If different than referring Provider):*_____