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

☐ **URGENT**

☐ **ROUTINE**

Mark ✓or X

LINE OF BUSINESS

☐ **CAREADVANTAGE**

☐ **MEDI-CAL**

☐ **ACE**

☐ **HEALTHWORX**

Today's Date: _____ MM-DD-YYYY

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

➢ **Member Last Name:** _____ First Name, M.I.: _____

Street Address: _____ City, State, ZIP: _____

Phone: _____ Member ID#: _____ DOB: _____ Age: _____

➢ **Requesting Provider:** _____ NPI: _____

Street Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____ Office Contact: _____

➢ **Servicing Provider (if needed):** Mental Health Association NPI: 1073678793

Phone: (650) 257-8816 Fax: (650) 507-4071 Office Contact: _____

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

Line No.	Procedure Code (CPT/HCPCS Code/Modifier if applicable)	Specific Services Requested	Units of Service (Days/Quantity)
1	H0043	Housing Navigation/Transition Services	6 units
2	S5130	Personal Care and Homemaker Services	400 units
3			
4			
5			
6			
7			
8			
9			
10			

Requested Service Dates FROM: MM-DD-YYYY **TO:** MM-DD-YYYY

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

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

PRINT FORM