

- AltaMed Health Services     Omnicare Medical Group     LaSalle Medical Associates     Family Choice Medical Group  
 Medi-Cal     Commercial     Medicare\*

**URGENT (72 HOURS)** Request submitted as urgent 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/\*14 CALENDAR DAYS)**

**RETRO (30 CALENDAR DAYS)** Request submitted within 30 calendar days from date of service    **Retro Date of Service:** \_\_\_\_\_

- Continuity of Care Last Visit Date: \_\_\_\_\_     Standing Referral     Second Opinion

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

For inquiries or questions on authorization status, or in general, call the Altura Customer Services Department at (323) 417-7741

**PATIENT INFORMATION**

**Patients Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Health Plan:** \_\_\_\_\_ **Health Plan ID:** \_\_\_\_\_

**AUTHORIZATION REQUEST INFORMATION**

<b>ICD-10:</b> _____	<b>Diagnosis Description:</b> _____
<b>CPT Code:</b> _____	<b>CPT Description:</b> _____
<b>CPT Qty:</b> _____	_____
_____	_____
_____	_____
_____	_____

**Referred To Provider**  
**Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_  
**Facility:** \_\_\_\_\_ **Place of Service (POS):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_ **NPI/Tax ID:** \_\_\_\_\_  
**Reason for referral:** \_\_\_\_\_

**Attachments:**

- Clinical     Laboratory & Radiology Findings     Medication List     Other

**Requesting Provider Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Primary Care Provider** (If different than Requesting Provider): \_\_\_\_\_

**Requesting Provider Signature:** \_\_\_\_\_

**For Home Health requests, in addition to the above section, please complete the following page.**

**HOME HEALTH SERVICES**

**Initial Start of Care (SOC):** \_\_\_\_\_ **Last Visit Date:** \_\_\_\_\_

Service Request	CPT Codes	Start Date	End Date	# of Visits	Frequency (# of Visits per Week)
RN					
PT					
OT					
ST					
HHA					
MSW					
Other					

**For Internal Use Only:**