Authorization Request

Instructions

Prior authorizations are not required for referrals to network specialists for initial consultations and one (1) follow-up appointment. Prior authorizations are required for additional specialist visits and all procedures and medical services listed in the table below. Use a Referral Request form to make a referral.

Authorization Request Instructions

Prior authorizations are required for all procedures and medical services listed in the table below, and for any specialist visits beyond initial and follow-up appointments. **Providers and facilities must be in network.** Complete this form and fax it to Utilization Management at (323) 337-9143. Routine authorization requests are processed within 14 days. Please call (800) 474-1434 for authorization status. Claim(s) will be paid if a prior authorization has been granted. Patient eligibility should be verified, see below.

Eligibility Verification

For **Positive Healthcare Partners (HMO SNP)** (Medicare Advantage Part D plan) eligibility verification, please call (800) 263-0067. For **Positive Healthcare California** (Medi-Cal HMO plan), please call (866) 644-5025.

Specialty Services Requiring Prior Authorization

- All inpatient care (acute, subacute, SNF, and long-term)
- Home health care, including skilled nursing, rehab, and home infusion
- Imaging studies (excluding mammography, x-ray and ultrasounds or single/flat view studies) and nuclear medicine
- Interventional radiology
- Outpatient surgery, rehabilitation including PT/OT/ST and chemotherapy
- Photo and radiation therapy
- Wound care
- Injectables (Part B) administered in physician's office other than immunizations administered by a PCP
- Durable medical equipment (DME)
- Dialysis in service area
- Colonoscopy and endoscopy
- EMG, nerve conduction studies
- Hearing aids
- Orthotics and prosthetics
- Cardiac testing (excluding EKG) and catheterization

Date of Request: _____ Check if Urgent ☐

Patient Information

_____
Patient Name

Select Plan Option:
☐ Positive Healthcare Partners
☐ Positive Healthcare California

_____ _____
Member ID Number Birth Date

_____ _____ _____ _____
Primary Care Provider Name | Contact | Phone | Fax

Referring Provider Information

_____ _____ _____ _____
Primary Care Provider Name | Contact | Phone | Fax

Indication for Referral

Diagnosis(es)/Code _____

CPT Code: _____

List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data _____

_____

Requested Consultation or Service _____

Requested (Refer to) Provider Information

_____ _____ _____
Requested Provider/Facility Name | Phone | Fax

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