Prior Authorization Request Form

Fax: **(415) 357-1292**

Telephone: **(415) 547-7818 ext.7080**

SAN FRANCISCO HEALTH PLAN
Here for you

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

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

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility 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 type of request: ☐ Urgent ☐ Routine ☐ Retroactive (Must be submitted within 30 calendar days of date of service)

PATIENT	REQUESTING PROVIDER
Name*:	Select one: ☐ Primary Care ☐ Specialist ☐ Vendor/Ancillary
SFHP ID#: Date of Birth*:	Name*:
Other Insurance (i.e. Medicare, Anthem):	Address:
Gender: ☐ Male ☐ Female ☐ Other:	City: State: Zip Code:
Telephone:	Telephone*:
Address:	Fax*:
City: State: Zip Code:	Email:

AUTHORIZE TO

Name / Facility / Vendor*: ☐ Out of Member's Medical Group ☐ Non-Contracted

Specialty*: Reason for out of medical group/non-contracted provider:

Address*:

City: State: Zip Code: NPI#:

DIAGNOSES / SERVICE CODES

At least one diagnosis and one service code required.*

ICD-9 Some ICD-9 codes require a 4th and/or 5th digit. Please document diagnosis completely.

CPT/HCPCS Code Indicate quantity and modifiers for each code. If no quantity indicated, the amount will default to 1. Ensure quantities are consistent with CPT/HCPCS values. Submit Medi-Cal covered codes when appropriate.

Code	Qty	Description	Code	Qty	Description	Code	Qty	Description

Select hospital status*: ☐ Inpatient, number of days: ☐ Outpatient **Date of Service:**

Select if you are including supporting documentation: ☐ Yes ☐ No

Contact Name: Direct Telephone: Fax:

Comments (not required):

Today's Date: