Pre-Authorization Request Form

Fax: **1(415) 357-1292** Telephone: **1(415) 547-7818 ext. 7080**

SAN FRANCISCO HEALTH PLAN™
Here for you

NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED.

TYPED ONLY - NO HANDWRITTEN FORMS

Select all that apply*: ☐ New Request ☐ Modify Auth #: ☐ Second Opinion ☐ Experimental (Not a benefit) ☐ Investigational

Select priority*: ☐ Routine ☐ Retro (Must be submitted within 30 calendar days of date of service)

Urgent (Select reason): ☐ Transplant Evaluation ☐ Transplant Procedure ☐ Hospital Discharge ☐ Inpatient Hospice ☐ Enteral Nutrition

☐ Other Urgent: Member's life, health, or ability to attain, maintain, or regain max function in serious jeopardy

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits 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: **sfhp.org/providers** 2. Interactive Voice Response: **1(415) 547-7810** 3. SFHP Customer Services: **1(800) 288-5555**

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

Does additional coverage exist?* ☐ Yes ☐ No If yes, specify the following: Carrier: Policy#:

PATIENT	REQUESTING PROVIDER
Name*:	☐ Primary Care Provider ☐ Specialist ☐ Vendor/Ancillary
SFHP ID#*: Date of Birth*:	Name*:
Telephone:	Telephone*:
Address:	**Contact Name:** Fax:
	Address:

RENDERING PROVIDER

Name / Facility / Vendor*:

Specialty*: NPI#:

Telephone*:

Contact Name: Fax*:

Address:

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

DIAGNOSES / SERVICE CODES

At least one valid diagnosis code **and** one valid service code are required.*

Diagnosis Codes: Please document diagnosis completely.

Service Codes: Indicate quantity and modifiers (if applicable) for each code. If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS values.

CODE	MOD	QTY	DESCRIPTION	CODE	MOD	QTY	DESCRIPTION

Select hospital status*: ☐ Inpatient ☐ Outpatient/Observation **Date of Service:**

Comments: Today's Date:

Important: Please attach appropriate clinical documentation to support your request.