SAN FRANCISCO HEALTH PLAN
Here for you

Please complete as much of the form as you can.
This will expedite and reduces confusion for our staff processing your request.
Mandatory fields on this Pre-Authorization Request Form:

- Type of Request
- Additional Coverage,
- Member's Name, Member's DOB,
- Requesting Provider's Name
- Requesting Provider's Phone Number
- Rendering Provider's Name and Specialty
- Rendering Provider's Telephone and Fax Number
- Diagnosis
- Service Codes
- Hospital Status

All services provided out of medical group, with the exception of emergency and sensitive services, require prior authorization.

Attention Non Contracted Providers:
By requesting prior authorization, the provider understands that SFHP covers benefits under the Medi-Cal (California Medicaid), Healthy Kids, or Healthy Workers programs.
The servicing provider agrees to accept SFHP's rates, which are based on the California Medi-Cal fee schedule for any covered services or the allowable amount for the coordination of benefits between Medicare (or other health coverage) and the Medi-Cal program.
San Francisco Health Plan will not authorize services that are not determined to be medically necessary.

Download the Pre-Authorization Request Form
Or find it at: http://www.sfhp.org/providers/authorizations/pre-authorizations/
Please fax completed forms to **1(415) 357-1292.**

Select all that apply: ☐ New Request ☐ Modification Request for Authorization #: ☐ Second Opinion **1**
Select type of request*: ☐ Urgent ☐ Routine ☐ Retro (Must be submitted within 30 calendar days of date of service) **2**
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: **www.sfhp.org/providers**
2. Interactive Voice Response: **(415) 547-7810**
3. SFHP Customer Services: **(800) 288-5555**

Select line of business: ☐ Medi-Cal ☐ Healthy Kids ☐ Healthy Workers
Does additional coverage exist?* ☐ Yes ☐ No If yes, specify the following: Carrier Policy# **3**

1. **Is this a new request?** Or a modification of an existing request (please indicate the authorization number to modify)? Or for a second opinion?

2. **Urgent:** 72 hours TAT – mark if member will require services in < 5 days to avoid adverse health outcomes or medically necessary services already scheduled to take place in < 5 days for which no prior authorization exists.

   Routine: 5 business days TAT – mark if member will require ongoing ambulatory services or does not require services in the next 72 hours.

   Retrospective: for services already rendered – must be submitted to SFHP within 30 days from date of service.

3. **Other Health Coverage** – does member have any additional coverage? (i.e. Medicare, Commercial plans such as Blue Cross, Blue Shield, etc…)

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PATIENT	4	REQUESTING PROVIDER	5
Name*:		☐ Primary Care Provider ☐ Specialist ☐ Vendor/Ancillary	
SFHP ID#:	Date of Birth*:	Name*:	
Gender: ☐ Male ☐ Female ☐ Other:		Telephone*:	
Telephone:		**Contact Name:**	Fax:
Address:		Address:	
City:	State: CA Zip:	City:	State: CA Zip:

4. **Member information:** Name and DOB are mandatory fields.
5. **Requesting Provider:** Name of Provider/Clinic and Contact information are mandatory fields. *Please include telephone extension/direct line/fax number to expedite your request.*

RENDERING PROVIDER	6		
Name / Facility / Vendor*:		☐ Out of Member's Medical Group	☐ Non-Contracted
Specialty*:	NPI#:	Reason for out of medical group/non-contracted provider:	
Telephone*:			
Contact Name:	Fax*:		
Address:			
City:	State: CA Zip:		

6. **Rendering Provider:** Name of Provider (if services will be performed at a facility, then name of facility should be used), Provider specialty, and provider contact information are mandatory fields.

DIAGNOSES / SERVICE CODES 7

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

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Select hospital status*: ☐ Inpatient, number of days: ☐ Outpatient **Date of Service:** 9

Comments: Today's Date:

Important: Please attach appropriate clinical documentation to support your request. 10

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7. **Diagnosis and CPT codes** (please include modifiers and total number of units for services to be performed) are mandatory fields. If more than 6 CPT codes are needed, please attach the list on a separate sheet and write "see attachment"
8. **Indicate hospital status:** if the member will be staying in the hospital after their services, what will be the anticipated number of days? *Please mark either Inpatient or Outpatient.*
9. **The date the service will be performed** (if known).
10. **Please provide all appropriate clinical** documentation to support and expedite the request.