Long-Term Care (LTC) – Authorization Request Form (ARF)
(for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Room and Board)

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department – Authorization Request Form (ARF) *(for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Room and Board)* is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Include the following attachments:
    a. Verification of Alliance eligibility
    b. Certification for Special Treatment Program Services Form HS 231 (required)
    c. Medical Review/Prolonged Care Assessment (DHCS 6013A) (required)
    d. Copy of the individual program plan (IPP) created by the member's regional center (if available).
    e. Copy of the individual service plan (ISP) for room and board reauthorization requests only (if available).
3. Please fax the completed form and attachments to the Alliance LTC Department at **1.510.747.4191**.

For questions, please call the Alliance LTC Department at **1.510.747.4516**.

PLEASE NOTE: Incomplete forms may be delayed or declined and returned to the referral source. Authorization does not guarantee payment. The Alliance reserves the right to request additional documentation as needed to make a determination. Alliance eligibility must be verified at the time services are rendered.

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____

Alliance Member ID # (if available): _____

Medi-Cal/Client Identification Number (CIN): _____

Primary Insurance: _____ Secondary Insurance: _____

SECTION 2: TYPE OF REQUEST

Please select only one (1):

- ☐ Routine
- ☐ Urgent (members being discharged from the hospital)
- ☐ Retro (use when the request is more than 30 days after admission)

SECTION 3: AUTHORIZATION REQUEST

Facility Admit Date: _____

Requested Start Date: _____ Requested End Date: _____

Please select only one (1):

- ☐ Initial
- ☐ Re-Admission
- ☐ Transfer Authorization
- ☐ Bed Hold (maximum of 7 days)
- ☐ Leave of Absence (maximum of 73 days per calendar year)

SECTION 4: PROVIDER INFORMATION

Facility Name: _____

Facility Contact Last Name: _____ Facility Contact First Name: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Facility Phone Number: _____ Facility Fax Number: _____

Physician Last Name: _____ Physician First Name: _____

Physician License Number: _____

Facility Type (please select only one (1)):

- ☐ Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- ☐ Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H)
- ☐ Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N)

Diagnosis/Diagnoses: _____

ICD Code(s): _____

SECTION 5: REFERRING PROVIDER INFORMATION

Last Name: _____ First Name: _____

Physician Signature: _____ Date: _____

*Signed physician order for appropriate level of care may be sent in lieu of signing ARF.

Additional Comments:

Member Last Name: _____ Member First Name: _____ CIN #: _____