ALAMEDA Alliance FOR HEALTH

Don't Handwrite or Stamp!
1. Download this PDF file and type.
2. All **bolded** fields are required.
3. Print and Fax the typed form.

Prior Authorization Request

Fax: (855) 891-7174 **Phone:** (510) 747-4540

Note: All **bolded fields** are required.
Handwritten or incomplete forms may be delayed.

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.

Member must be eligible on date of service and procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT. If interested in becoming an Alliance contracted provider, contact Provider Services at (510) 747-4510. Please verify eligibility at https://www.alamedaalliance.org.

☐ **Clinicals are required to be submitted with this form. Please check this box to certify clinicals have been attached**.

TYPE OF REQUEST (please check only one):

☐ **Routine** Approval based on AAH clinical review. AAH has up to 5 business days to process routine requests.

☐ **Urgent** Inappropriate use will be monitored. AAH has up to 72 hours to process urgent requests for all lines of business.

☐ **Retro** Only granted for member eligibility issues on DOS or for services rendered in emergent or urgent situations. Alliance has up to 30 calendar days to process retro requests.

☐ **Modification** Request for existing authorized services. Please enter the AAH Auth Number and the Member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

If Mod, Alliance AUTH #:

REQUESTING PROVIDER

Name:	
Address:	
City:	**State:** **Zip:**
NPI #:	**Tax ID:**
Office Contact:	
Phone:	**Fax:**
Email:	

MEMBER (For newborn services provide mother's information)

First Name:	**Health Plan ID#:**
Last Name:	**Phone:**
Date of Birth:	**Other Insurance (i.e. Commercial, Medicare A, B):**
Address:	
City: **State:** **Zip:**	

RENDERING PROVIDER/FACILITY

Name/Facility:	**Phone:**
Specialty/Dept:	**Fax:**
NPI #: **TIN #:**	**Address:**
Date of Service From: **To:**	**City:** **State:** **Zip:**

PLACE OF SERVICE (Check one – please do not circle):

☐ Inpatient Hospital ☐ Ambulatory Surgical Ctr.
☐ Outpatient Hospital ☐ Home
☐ Provider's Office ☐ DME

Non-Contracted (Check one – please do not circle):

☐ Patient Request ☐ Provider not accepting new patients
☐ Provider Not Available ☐ Specialized Procedure / Area of expertise
☐ Timely Access to provider ☐ Other _____

DIAGNOSES / SERVICE CODES Please DO NOT describe the procedures; only enter the Code, Modifier, and Quantity.

ICD-10 Code(s):									

CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty