Behavioral Health (BH) Care – Prior Authorization (PA) Request Form

The Alameda Alliance for Health (Alliance) Behavioral Health (BH) Care – Prior Authorization (PA) Request Form is confidential. Filling out this form will help us better serve our members. Authorizations are based on medical necessity and covered services. Authorizations are contingent upon the member's eligibility and are not a guarantee of payment. The provider is responsible for verifying the member's eligibility on the date of service. The member must be eligible on the date of service and the procedure must be a covered benefit. **THE REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT.**

INSTRUCTIONS

1. Please type in all of the fields below. All fields with an (*) are required. Do not handwrite or stamp.
2. Please fax the completed form to the Alliance Behavioral Health Department at **1.855.891.9163** or send a secure email to **deptbhaba@alamedaalliance.org**.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

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

*SECTION 1: TYPE OF REQUEST

Please select only one (1):

- ☐ **Routine** – Approval based on Alliance clinical review. The Alliance has up to five (5) business days to process routine requests.
- ☐ **Urgent** – Inappropriate use will be monitored. The Alliance 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. The Alliance has up to 30 calendar days to process retro requests.
- ☐ **Modification** – Request for existing authorized services. Please enter the Alliance Auth # and the member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

*If **Modification,** Alliance Auth #: _____

SECTION 2: REQUESTING PROVIDER

*Last Name: _____

*First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*NPI #: _____ *TIN: _____

Office Contact: _____

*Phone Number: _____

*Fax Number: _____

Email: _____

SECTION 3: MEMBER INFORMATION

*Last Name: _____ *First Name: _____

*Date of Birth (MM/DD/YYYY): _____ *Alliance Member ID #: _____

Address: _____ Other Insurance (i.e., Commercial, Medicare A, B):

City: _____ State: _____ Zip Code: _____ _____

Phone Number: _____

SECTION 4: RENDERING PROVIDER/FACILITY INFORMATION

*Name/Facility: _____ *Phone Number: _____

Specialty/Dept.: _____ *Fax Number: _____

*NPI #: _____ *TIN: _____ Address: _____

Date of Service From: _____ To: _____ City: _____ State: _____ Zip Code: _____

*Place of Service (please select only one (1)):

☐ Ambulatory Surgical Ctr. ☐ Custodial ☐ DME ☐ ICF

☐ Outpatient Hospital ☐ Provider's Office ☐ Skilled ☐ Subacute

*Non-Contracted (please select only one (1)):

☐ Patient Request ☐ Provider not accepting new patients ☐ Provider not available

☐ Specialized procedure/ area of expertise ☐ Timely access to the provider ☐ Other: _____

SECTION 5: DIAGNOSIS/SERVICE CODES

Please DO NOT describe the procedures; only enter the Code, Modifier (MOD), and Quantity (QTY).

*ICD-10 Code(s):									

*CPT/HCPCS	MOD	*QTY	CPT/HCPCS	MOD	QTY	CPT/HCPCS	MOD	QTY