Community Supports (CS) Authorization Request Form (ARF)

Please use this form to request authorization for Alameda Alliance for Health (Alliance) Medi-Cal or Alameda Alliance Wellness (HMO D-SNP) members. Authorizations are based on the appropriateness of the requested service, contingent upon the member's eligibility, and do not guarantee payment. This form is confidential.

The provider is responsible for verifying the members' eligibility on the date of service. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal.

To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click the Provider Portal button in the top-right corner of our home page. You will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond. If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**.

Instructions

1. Please print clearly or type in all the fields below, as appropriate.
2. Attach a clinical summary and/or supporting documentation (i.e., clinic notes, hospital discharge summary, etc.) for the requested Community Support.
3. Submit the completed form and any supporting documentation to the Alliance Community Supports Department via fax at **1.510.995.3726** or secure email at **CSDept@alamedaalliance.org**.

Please note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. For questions, please call the Alliance Community Supports Department at **1.510.747.4545**.

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

Section 1: Requesting Provider Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

National Provider Identifier (NPI): _____ Tax ID Number (TIN): _____

Office Contact Person Full Name: _____

Phone Number: _____ Fax Number: _____

Email: _____

Date of Request: _____

Service Start Date: _____ Service End Date: _____

Section 2: Member Information

Last Name: _____ First Name: _____

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

Alliance Member ID Number: _____ Client Index Number (CIN): _____

Medicare Beneficiary Identifier (MBI): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Primary Diagnosis (including ICD-10 code(s)): _____

Is the member currently linked to a case management (ECM/CM) team? ☐ Yes ☐ No

Case Manager/ECM Name: _____

Case Manager/ECM Phone Number: _____

Section 3: Servicing Provider Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

National Provider Identifier (NPI): _____ Tax ID Number (TIN): _____

Phone Number: _____ Fax Number: _____

Email: _____

Section 4: Requested Service(s)

Type of Request

Please select only one (1):

☐ Initial Request

☐ Extension Request

Previous Authorization Number: _____

Section 4: Requested Service(s) (cont.)

Please select all that apply:

Assisted Living Facility (ALF) Transitions

- ☐ H2022 (U5) – Community Wrap-Around Services: Ongoing Assisted Living Services
- ☐ T2038 (U4) – Community Transition: Transition Services and Expenses

Asthma Remediation

- ☐ S5165 – Home Modification
  Units/Description: _____

Community or Home Transition Services

- ☐ T2038 (U5) – Community or Home Transition Services: Transition Services and Expenses
- ☐ H0044 (U5) – Nonrecurring Set-Up Expenses

Housing Bundle

- ☐ H0043 (U6) – Housing Transition Navigation
- ☐ H0044 (U2) – Housing Deposits
- ☐ T2051 (U6) – Tenancy Sustaining Services

Environmental Accessibility Adaptations (Home Modifications)

- ☐ S5161 (U6) – Personal Emergency Response System
- ☐ S5165 (U6) - Home Modification, Per Service

Medically Tailored Meals (MTM)/Medically Supportive Food (MSF)

Meal Frequency Request

- ☐ S5170 (U6) – One (1) Medically Tailored Meal Per Day
- ☐ S5170 (U6) – Two (2) Medically Tailored Meals Per Day

Medically Tailored Groceries

- ☐ S9977 (U6) – Medically Tailored Grocery Box, Per Week

Medically Supportive Food

- ☐ S9452 (U5) – Nutritional Education-Individual
  Number of Sessions (15 minutes): _____
- ☐ S9452 (U6) – Nutritional Education-Group
  Number of Sessions (15 minutes): _____
- ☐ S9470 (U6) – Nutritional Assessment
  Number of Sessions (15 minutes): _____
- ☐ S9977 (U4) – Produce Box, Per Week
- ☐ S9977 (U7) – Medically Supportive Grocery Box, Per Week

Section 4: Requested Service(s) (cont.)

Personal Care and Homemaker Services (PCHS)

☐ S5130 (U6) Home Maker Services (>18 years of age)

Units: _____

☐ T1019 (U6) Personal Care

Units: _____

Respite Services

☐ H0045 (U6) – Not in the Home

☐ S9125 (U6) – In the Home

☐ S5151 (U6) – Unskilled

Units: _____

Recuperative Care (Medical Respite)

☐ T2033 (U6)

Days Requested: _____

Transitional Rent

☐ H0044 (U6) – Permanent Settings

☐ H0043 (U3) – Interim Settings

Section 5: Patient's Medical Necessity

Please describe and attach all supporting documentation to the form:

_____

_____

_____

_____

_____

_____

_____

_____

_____