ALAMEDA Alliance FOR HEALTH

Authorization Request Form

(Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Room and Board)

Please use this form to request authorization for Alameda Alliance for Health (Alliance) Medi-Cal and Alameda Alliance Wellness (HMO D-SNP) members. Authorizations are based on medical necessity and covered services. 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 member's eligibility on the date of service. The Alliance member must be eligible on the date of service, and the procedure must be a covered benefit. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal. The remaining balance may not be billed to the patient.

To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click on 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 of the fields below. All fields marked with (*) are required.
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. Print and fax the completed form and attachments to the Alliance Long-Term Care (LTC) Department at **1.510.747.4191**.

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

☐ ***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

Facility Name: ______________________________

*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: ______________________________

Section 2: Type of Request

*Please select only one (1):

☐ **Retro** – Request for members who have already been admitted. Granted for eligibility issues or urgent care. Requests must be within 90 days of the date of service. Processing time is up to 30 calendar days from receipt.

☐ **Routine** – Based on Alliance clinical review. The Alliance has up to seven (7) calendar days to process routine requests for all lines of business.

- ☐ Initial Authorization (ICF/DD)
- ☐ Reauthorization (ICF/DD)

☐ **Urgent** – Defined as a request for medical services that needs prompt decision because a member's condition presents as an imminent and serious threat to the member's health, such as a potential loss of life, limb, or a major bodily function. Inappropriate use will be monitored. The Alliance has up to 72 hours to process urgent requests for all lines of business.

- ☐ Hospital D/C to ICF/DD

☐ **Authorization Change Request** – Request for existing authorized services. Please enter the Alliance authorization number and the member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

*If **Authorization Change Request**, please provide the Alliance Authorization Number:

____

Section 3: 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: ____________________

*Other Insurance (please select all that apply, and include the name of your insurance):

☐ Commercial: ____________________

☐ Medi-Cal: ____________________

☐ Medicare: If yes, please complete **Section 4: Medicare/Benefit Status**.

Section 4: Medicare/Benefit Status

Medicare Status (please select all that apply): ☐ A ☐ B ☐ C ☐ D

Benefit Status (please select only one (1)):

☐ Benefits exhausted:

- Date Medicare Benefits Exhausted (MM/DD/YYYY): ____________________
- Dual Eligible Special Needs Plan (D-SNP)
- Please attach the Notice of Medicare Non-Coverage (NOMNC)

☐ Benefits **NOT** exhausted:

- Number of Medicare Days Available: ____________________
- Other Dual Eligible Special Needs Plan (D-SNP)

Section 5: Servicing Facility Information

*Facility Name: ____________________

*Address: ____________________

*City: ____________________ *State: ______ *Zip Code: __________

*National Provider Identifier (NPI): ____________ *Tax ID Number (TIN): ____________

*Phone Number: ____________________ *Fax Number: ____________________

Facility Contact Person Full Name: ____________________

Section 6: Admission Source/Referral Information

Please select only one (1):

- [ ] Acute hospital
- [ ] Board and care/assisted living facility
- [ ] Emergency Room
- [ ] Home
- [ ] LTC custodial
- [ ] Physician referral
- [ ] SNF
- [ ] Street
- [ ] Transfer from hospital
- [ ] Transfer from residential facility
- [ ] Transfer from another healthcare facility

Date of ICF/DD Placement Referral (MM/DD/YYYY): ______________________________

Reason for ICF/DD Placement: ____

Section 7: Out-of-Network Information

*Is the service being requested out-of-network: [ ] Yes [ ] No

If **Yes**, provide the reason for out-of-network facility/provider (please select only one (1)):

- [ ] Continuity of Care (CoC)
- [ ] In-network provider not accepting new patients
- [ ] In-network provider type, specialty, or covered service not available
- [ ] Patient request
- [ ] Specialized procedure/area of expertise
- [ ] Timely access to provider
- [ ] Other: ____________________

Section 8: Level of Care Requested

Please select only one (1) level of care per request form.

*Requested Start Date: ________________ *Requested End Date: ________________

*Diagnosis: ____

*Diagnosis (ICD) Code(s): ______________________________________

Type of Facility

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)

Section 8: Level of Care Requested (cont.)

Please select only one (1) level of care per request form.

ICF/ DD, ICF/DD-H, ICF/DD-N Room and Board

☐ ICF/DD – Regular

Bed Hold (maximum of seven (7) days) (if selected, please include MD orders for transfer and bed hold)

☐ ICF/DD – Bed hold (maximum of seven (7) days)

Leave of Absence (maximum of 73 days per calendar year)

☐ ICF/DD – Leave of absence

Section 9: Member’s General Condition

Please select all that apply:

☐ Ambulatory

☐ Ambulatory with assistance

☐ Confined to bed

☐ Confined to wheelchair

☐ Incontinent of bowel and bladder

☐ Maximum assistance with all activities of daily living (ADLs)

Section 10: Additional Comments

Additional Comments: