



Long-Term Care – Prior Authorization (PA) Request Form (for Ancillary Services)

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department Prior Authorization (PA) Request Form (for Ancillary Services) 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. Member must be eligible on the date of service and 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 Long-Term Care (LTC) Department at **1.510.747.4191**.

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 clinicals have been attached.

*SECTION 1: TYPE OF REQUEST	SECTION 2: REQUESTING PROVIDER
<p>Please select only one (1):</p> <p><input type="checkbox"/> Routine – Approval based on Alliance clinical review. The Alliance has up to five (5) business days to process routine requests.</p> <p><input type="checkbox"/> Urgent – Inappropriate use will be monitored. The Alliance has up to 72 hours to process urgent requests for all lines of business.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p>*If Modification, Alliance Auth #: _____</p>	<p>*Last Name: _____</p> <p>*First Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>*NPI #: _____ *TIN: _____</p> <p>Office Contact: _____</p> <p>*Phone Number: _____</p> <p>*Fax Number: _____</p> <p>Email: _____</p>

SECTION 3: MEMBER INFORMATION	
<p>*Last Name: _____</p> <p>*Date of Birth (MM/DD/YYYY): _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Phone Number: _____</p>	<p>*First Name: _____</p> <p>*Alliance Member ID #: _____</p> <p>Other Insurance (i.e., Commercial, Medicare A, B): _____</p>

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	