Long-Term Care – Authorization Request Form (ARF)

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department Authorization Request Form (ARF) is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Include the following attachments:
   a. Verification of Alliance eligibility
   b. Completed LTC Request for Referral Form (RRF) and physician order with physician signature
   c. Documentation to support the level of care requested (Interdisciplinary Team (IDT) Evaluation, Minimum Data Set (MDS) 3.0, etc.)
3. 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**.

PLEASE NOTE: Incomplete forms may be delayed or declined and returned to the referral source. Authorization does not guarantee payment. Alliance eligibility must be verified at the time the services are rendered.

SECTION 1: AUTHORIZATION REQUEST

Type of Request *(please select only one (1)*:

- ☐ Bed Hold/Leave of Absence
  Start Date: _____
- ☐ Initial
- ☐ Re-Authorization
- ☐ Retroactive Eligibility
- ☐ Skilled Nursing Facility (SNF)
- ☐ Sub-Acute (Non-Vent)
- ☐ Sub-Acute (Vent)

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Language: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Alliance Member ID #: _____ Client Identification Number (CIN): _____

Aid Code: _____ County Code: _____

Primary Insurance: _____ Secondary Insurance: _____

SECTION 2: MEMBER INFORMATION (CONT.)

Medicare Status: _____

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 Plans (D-SNP)

SECTION 3: PROVIDER INFORMATION

Facility Name: _____

Facility Contact Last Name: _____ Facility Contact First Name: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Facility Phone Number: _____ Facility Fax Number: _____

Physician Last Name: _____ Physician First Name: _____

Physician Phone Number: _____ Physician Fax Number: _____

Diagnosis/Diagnoses: _____

IDC-9 Codes: _____

SECTION 4: ADMISSION SOURCE

Please select only one (1):

☐ Acute hospital
☐ Board & care
☐ Emergency room
☐ Home
☐ SNF

SECTION 5: REFERRAL INFORMATION

Date of LTC Placement Referral (MM/DD/YYYY): _____

Community Options Available: ☐ Yes ☐ No Type of Options: _____

Reason for LTC SNF Placement: _____

SECTION 6: PATIENT'S GENERAL CONDITION

Please select all that apply:

- ☐ Ambulatory
- ☐ Ambulatory with assistance
- ☐ Confined to bed
- ☐ Incontinent of bowel and bladder
- ☐ Maximum assistance with all ADLs
- ☐ Wheelchair confined

SECTION 7: REFERRING PROVIDER INFORMATION

Last Name: _____ First Name: _____

Additional Comments: