

Speed Up Your Faxed AAH Prior Auth Requests

For quickest processing, please check the list below
and be sure to follow these instructions:

➤ **Download and save** the new AAH Prior Auth Request Form as a PDF file from:

tinyurl.com/AAH-Auth



➤ Please **do not handwrite!** Type into the PDF form and print it out. You can save data in fields that you reuse often, such as your contact information.

➤ Run a **cleaning sheet** through your Fax machine. Office supply stores carry them.

➤ Please **do not circle or stamp** on the form. Circling, writing or stamping “URGENT” does not make the request go faster – it only slows processing.

➤ Avoid photocopying or re-faxing the request form. **Do not reduce the size** of the original, and don't fax sideways.

➤ Enter all required fields, such as Requesting and Rendering Provider names and all contact information. Do not write “SAME” or “See Attached Pages” – fill out each field as labeled.

➤ Do not describe requested procedures on this form. **Only enter the CPT Code / Modifier and Quantity** in the designated fields. Word descriptions will be skipped.

➤ Please do not write general comments, explanations, or requests on this form. Fill out each field with the requested information and use a separate attachment for comments as needed.

➤ Only enter a **Reason for Out of Network Request** if the Non-Contracted box is checked. Do not use this space for general comments, explanations, or requests.

➤ **Do not change the font size** or redesign the PDF form by adding, removing, or expanding fields. Your request will go much faster if you follow these instructions.

		ALAMEDA FOR HEALTH		Don't Handwrite or Stamp! 1. Download this PDF file and type. 2. All highlighted fields are required. 3. Print and Fax the typed form.		Prior Authorization Request Fax: (855) 891-7174 Phone: (510) 747-4540 Note: All HIGHLIGHTED fields are required. Handwritten or incomplete forms may be delayed.	
<small>Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Member must be eligible on date of service and procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT. If interested in becoming an Alliance contracted provider or to verify eligibility, contact Provider Services at (510) 747-4510 or visit https://www.alamedaalliance.org. </small>							
<input checked="" type="checkbox"/> Clinicals are required to be submitted with this form. Please check this box to certify clinicals have been attached.							
TYPE OF REQUEST (please check only one):				REQUESTING PROVIDER			
<input type="checkbox"/> Routine Approval based on AAH clinical review. AAH has up to 5 business days to process routine requests.				Name: Sergei Prokofiev			
<input checked="" type="checkbox"/> Urgent Inappropriate use will be monitored. AAH has up to 22 hours to process urgent requests for all lines of business.				Address: 3 Orange Square			
<input type="checkbox"/> Retro Only granted for member eligibility issues on DOS or for services rendered in emergent or urgent situations. Alliance has up to 30 calendar days to process retro requests.				City: Moscow State: RU Zip: 12345			
<input type="checkbox"/> Modification Request for existing authorized services. Please enter the AAH Auth Number and the Member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.				NPI #: 3141599296 Tax ID:			
				Office Contact: Nikolai			
				Phone: 666-123-1313 Fax: 666-123-0002			
If Mod, Alliance AUTH #:				Email:			
MEMBER (For newborn services provide mother's information)							
First Name: Pyotr Llyich				Health Plan ID#: 662608957			
Last Name: Tchaikovsky				Phone:			
Date of Birth: 5/07/1840				Other Insurance (i.e. Commercial, Medicare A, B):			
Address: 1812 Oengin Blvd							
City: Saint Petersburg State: RU Zip: 98785							
RENDERING PROVIDER/FACILITY							
Name/Facility: Mayo Clinic				Phone: 507-555-5670			
Specialty/Dept: Club Sandwiches				Fax: 507-266-5671			
NPI #: 181033988 TIN #:				Address: 200 First Street			
Date of Service From:				City: Rochester State: MN Zip: 55905			
To:							
PLACE OF SERVICE (Check one – please do not circle):							
<input type="checkbox"/> Inpatient Hospital		<input type="checkbox"/> Ambulatory Surgical Ctr.		<input checked="" type="checkbox"/> Non-Contracted. Provide reason for out of network request.			
<input checked="" type="checkbox"/> Outpatient Hospital		<input type="checkbox"/> Home		No provider in network that can provide the service.			
<input type="checkbox"/> Provider's Office		<input type="checkbox"/> DME					
DIAGNOSES / SERVICE CODES Please DO NOT describe the procedures; only enter the Code, Modifier, and Quantity.							
ICD-10 Code(s): 123.45 678.90 987.65							
CPT/HCPCS Mod Qty CPT/HCPCS Mod Qty CPT/HCPCS Mod Qty CPT/HCPCS Mod Qty							
97813 7 97814 7							
<small>NOTE: The information being transmitted contains information that is confidential, privileged and exempt from disclosure under applicable law. It is intended solely for the use of the individual or the entity to which it is addressed. If you have received this communication in error, please immediately notify us.</small>							