Palliative Care Prior Authorization Request

The Alameda Alliance for Health (Alliance) Health Authorization Department Palliative Care Prior Authorization Request 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. Please fax the completed form to the Alliance Health Authorization Department at **1.855.891.7174**.

For questions, please call the Alliance Utilization Management Department at **1.510.747.4540**.

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: ______________________ NPI: ______________

Address: ______________________

City: ______________ State: ________ Zip Code: ________

Phone Number: ______________ Fax Number: ______________

Email: ______________________

Office Contact Name: ______________ Date of Referral: ______________

SECTION 2: RENDERING PROVIDER INFORMATION

Full Name: ______________________ NPI: ______________

Address: ______________________

City: ______________ State: ________ Zip Code: ________

Phone Number: ______________ Fax Number: ______________

SECTION 3: MEMBER INFORMATION

First Name: ______________ Last Name: ______________

Date of Birth (MM/DD/YYYY): ______________ Alliance Member ID #: ______________

Address: ______________________

City: ______________ State: ________ Zip Code: ________

Phone Number: ______________ ☐ Home ☐ Cell

SECTION 4: REQUESTING SERVICE(S)

GENERAL ELIGIBILITY

Please select only one (1):

- ☐ Patient has documentation of decline in health status and is not eligible for hospice.
- ☐ Patient is eligible for hospice but declines.

MEMBER'S QUALIFYING CONDITION

Please select all that apply, must meet at least one (1) to be eligible:

- ☐ Advanced Heart Failure ([NYHA class 3 OR EF <30%] + at least one (1) hospitalization in the past six (6) months) **ICD-10 Code(s): ___________**
- ☐ Advanced COPD ([severely depressed FEV1 on PFT's OR 24-hour oxygen dependence] + at least one (1) hospitalization in past six (6) months) **ICD-10 Code(s): ___________**
- ☐ Advanced Liver Disease ([serum albumin <3, INR >1.3, ascites and one (1) or more complications including SBP, hepatic encephalopathy, hepatorenal syndrome, or esophageal varices or MELD score >19] + at least one (1) hospitalization in the past six (6) months) **ICD-10 Code(s): ___________**
- ☐ Advanced Cancer (stage 3 or 4 solid organ cancer or lymphoma or leukemia + KPS score ≤70) **ICD-10 Code(s): ___________**
- ☐ Advanced Dementia/Alzheimer's Dementia. Must meet four (4) out of five (5) criteria (profound memory deficits, functional impairment (ADL dependencies), minimal communication, decreased oral intake and/or significant weight loss in last six (6) months, malnutrition) **ICD-10 Code(s): ___________**

DESIRED LOCATION OF SERVICES

Please select only one (1):

- ☐ Home
- ☐ Clinic

CPT CODES

Please select all that apply, and indicate the quantity for each code (up to one (1) code per grouping):

- ☐ 99304 NURSING FACILITY CARE INIT
- ☐ 99305 NURSING FACILITY CARE INIT
- ☐ 99306 NURSING FACILITY CARE INIT
- ☐ 99307 NURSING FAC CARE SUBSEQ
  Quantity: ___________
- ☐ 99334 DOMICIL/R-HOME VISIT EST PAT
  Quantity: ___________
- ☐ 99341 HOME VISIT NEW PATIENT
- ☐ 99342 HOME VISIT NEW PATIENT
- ☐ 99343 HOME VISIT NEW PATIENT
- ☐ 99344 HOME VISIT NEW PATIENT
- ☐ 99345 HOME VISIT NEW PATIENT
- ☐ 99347 HOME VISIT EST PATIENT
  Quantity: ___________________
- ☐ 99348 HOME VISIT EST PATIENT
  Quantity: ___________________
- ☐ 99349 HOME VISIT EST PATIENT
  Quantity: ___________________
- ☐ 99350 HOME VISIT EST PATIENT
  Quantity: ___________________
- ☐ 99497 ADVNCD CARE PLAN 30 MIN
  Quantity: ___________________
- ☐ 99498 ADVNCD CARE PLAN ADDL 30 MIN
  Quantity: ___________________