Prior Authorization (PA) Request Form

The Alameda Alliance for Health (Alliance) Prior Authorization Request Form is confidential. Please use this form to request prior authorization for all Alliance lines of business (i.e., Medi-Cal, Group Care, and Alameda Alliance Wellness (HMO D-SNP)). 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. The Alliance member must be eligible on the date of service, and the procedure must be a covered benefit. The remaining balance may not be billed to the patient.

If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal. 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, and 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.

INSTRUCTIONS

1. Only type responses in all the fields below. Do not handwrite or stamp.
2. All fields marked with (*) are required.
3. Print and fax the completed typed form to the Alliance Utilization Management (UM) Department at **1.855.891.7174**.

Please Note: Handwritten or incomplete forms may be delayed. If you have any questions, please call the Alliance UM Department at **1.510.747.4540**.

☐ ***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: _____

*NPI Number: _____ *Tax ID Number: _____

Office Contact Person Full Name: _____

*Phone Number: _____ *Fax Number: _____

Email: _____

Section 2: Type of Request

*Please select only one (1):

☐ **Medication (Physician-Administered Drug, PAD) –** Please see below for the time that the Alliance has to process medication requests:

	Medi-Cal	Group Care	Alameda Alliance Wellness (HMO D-SNP)
☐ Routine (Approval based on Alliance clinical review)	24 hours	7 calendar days	72 hours
☐ Urgent (Inappropriate use will be monitored)	24 hours	72 hours	24 hours

☐ **Retro** – 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.

☐ **Standing Referral** – The Alliance has up to three (3) business days to process requests for standing referrals.

☐ **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 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.

☐ **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

For newborn services, provide the mother's 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: _____

Section 4: Requested Service

*Please select one (1) service from **either** Outpatient and Elective Services **or** Behavioral Health Services. **Do not** select from both categories.

Outpatient and Elective Services

Please select only one (1):

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Clinical Trials
- ☐ Community Based Adult Services (CBAS)
- ☐ Dialysis (out of network)
- ☐ Durable Medical Equipment (DME)/Supplies
- ☐ Gender Affirming Care
- ☐ Genetic Testing
- ☐ Inpatient Elective Surgery
- ☐ Laboratory/Pathology
- ☐ Outpatient (OP) Surgery
- ☐ Physical Therapy/ Occupational Therapy/ Speech Therapy
- ☐ Physician Administered Drug (PAD)
- ☐ Podiatry
- ☐ Private Duty Nursing (PDN)
- ☐ Prosthetics
- ☐ Radiology
- ☐ Specialty Referral
- ☐ Stanford Oncology
- ☐ Tertiary/ Quaternary Care (T/Q)
- ☐ Transgender Services
- ☐ Transplant Evaluation
- ☐ Transplant Surgery

Behavioral Health Services

Please select only one (1):

- ☐ Applied Behavioral Analysis (ABA)/ Behavioral Health Therapy (BHT)
- ☐ Behavioral Health (Mental Health/ Substance Use Disorders)

Section 6: Rendering/Servicing Provider Information

*Last Name: _____ *First Name: _____

Specialty: _____

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*NPI Number: _____ *Tax ID Number: _____

*Phone Number: _____ *Fax Number: _____

*Starting Service Date: _____ Ending Service Date (if known): _____

*Place of Service (please select only one (1)):

- ☐ Durable Medical Equipment (DME)
- ☐ Office (11)
- ☐ Home (12)
- ☐ Inpatient Hospital (21)
- ☐ Outpatient Hospital (22)
- ☐ Ambulatory Surgical Center (24)

Section 7: Rendering/Servicing Facility Information (if applicable)

Facility Name: _____

Department: _____

Address: _____

City: _____ State: _____ Zip Code: _____

NPI Number: _____ Tax ID Number: _____

Phone Number: _____ Fax Number: _____

Section 8: 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)):

- ☐ In-network provider not accepting new patients
- ☐ In-network provider not available
- ☐ Patient request
- ☐ Specialized procedure/Area of expertise
- ☐ Timely access to provider
- ☐ Other: _____

Section 9: Discharge Planning Information

*Is the service needed for discharge planning: ☐ Yes ☐ No

If **Yes**, what is the discharge date (MM/DD/YYYY)? _____

Section 10: Diagnoses/Service Codes
At least one (1) diagnosis code is required.

*ICD Code(s)	Primary (Check only if **yes**)	ICD Code(s)	Primary (Check only if **yes**)
	☐		☐
	☐		☐
	☐		☐
	☐		☐

*Code CPT/HCPCS	*Description	Modifier 1	Modifier 2	Quantity	Unit Type	Total Billable Units