ALAMEDA Alliance 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.

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, contact Provider Services at (510) 747-4510. Please verify eligibility at https://www.alamedaalliance.org.

☐ **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):

☐ **Routine** Approval based on AAH clinical review. AAH has up to 5 business days to process routine requests.

☐ **Urgent** Inappropriate use will be monitored. AAH has up to 72 hours to process urgent requests for all lines of business.

☐ **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.

☐ **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.

If Mod, Alliance AUTH #:

REQUESTING PROVIDER

Name:	
Address:	
City: State: Zip:	
NPI #:	Tax ID:
Office Contact:	
Phone:	**Fax:**
Email:	

MEMBER (For newborn services provide mother's information)

First Name:	**Health Plan ID#:**
Last Name:	Phone:
Date of Birth:	Other Insurance (i.e. Commercial, Medicare A, B):
Address:	
City: State: Zip:	

RENDERING PROVIDER/FACILITY

Name/Facility:		**Phone:**
Specialty/Dept:		**Fax:**
NPI #:	**TIN #:**	Address:
Date of Service From:	To:	City: State: Zip:

PLACE OF SERVICE (Check one – please do not circle):

☐ Inpatient Hospital ☐ Ambulatory Surgical Ctr.
☐ Outpatient Hospital ☐ Home
☐ Provider's Office ☐ DME

☐ **Non-Contracted.** Provide reason for out of network request.

DIAGNOSES / SERVICE CODES **Please DO NOT describe the procedures; only enter the Code, Modifier, and Quantity.**

ICD-10 Code(s):									

CPT/HCPCS	Mod	**Qty**	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty