# ALTURA AUTHORIZATION REQUEST FORM

**Request Date:** _____ ☐ **AltaMed Health Services** ☐ **Omnicare Medical Group** ☐ **LaSalle Medical Associates**

☐ **Medi-Cal** ☐ **Commercial** ☐ **Medicare***

☐ **URGENT (72 HOURS)** *Request submitted as urgent when standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.*

☐ **ROUTINE (5 BUSINESS DAYS/*14 CALENDAR DAYS)**

☐ **RETRO (30 CALENDAR DAYS)** *Request submitted within 30 calendar days from date of service* **Retro Date of Service:** _____

☐ **Continuity of Care** *Last Visit Date:* _____ ☐ **Standing Referral** ☐ **Second Opinion**

**SUBMIT AUTHORIZATION REQUEST VIA FAX TO (323) 720-5608**

*For inquiries or questions on authorization status, or in general, call the Altura Customer Services Department at (323) 417-7741*

## PATIENT INFORMATION

**Patients Name:** _____ **DOB:** _____

**Health Plan:** _____ **Health Plan ID:** _____

## AUTHORIZATION REQUEST INFORMATION

| | | | | |
|---|---|---|---|---|
| **ICD-10:** | | | **Diagnosis Description:** | |
| **CPT Code:** | | **CPT Qty:** | **CPT Description:** | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Referred To Provider Name:** _____ **Specialty:** _____

**Facility:** _____ **Place of Service (POS):** _____

**Address:** _____

**Telephone:** _____ **NPI/Tax ID:** _____

**Reason for referral:** _____

**Attachments:**

☐ **Clinical** ☐ **Laboratory & Radiology Findings** ☐ **Medication List** ☐ **Other**

**Requesting Provider Name:** _____

**Address:** _____

**Telephone:** _____ **Fax:** _____

**Primary Care Provider** *(If different than Requesting Provider)*: _____

**Requesting Provider Signature:** _____

***For Home Health requests, in addition to the above section, please complete the following page.***

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## HOME HEALTH SERVICES

**Initial Start of Care (SOC):** _____ **Last Visit Date:** _____

| Service Request | CPT Codes | Start Date | End Date | # of Visits | Frequency (# of Visits per Week) |
|---|---|---|---|---|---|
| **RN** | | | | | |
| **PT** | | | | | |
| **OT** | | | | | |
| **ST** | | | | | |
| **HHA** | | | | | |
| **MSW** | | | | | |
| **Other** | | | | | |

**For Internal Use Only:**