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 (855) 848-5252.

PATIENT INFORMATION

Patients Name: _____ **DOB:** _____

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

AUTHORIZATION REQUEST INFORMATION

ICD-10: _____ **Diagnosis Description:** _____

_____ _____

CPT Code: _____ **CPT Description:** _____

_____ _____

Referred To Provider Name: _____ **Facility:** _____

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 Internal Use Only: