REQUEST FOR CATARACT SURGERY

Humboldt IPA Authorization Request Form

Fax completed form to 707-442-2047 or mail to the IPA, 2662 Harris Street, Eureka, CA 95503

Phone: 707 443-4563; we do not accept authorization requests over the phone.

Incomplete request forms will be returned without being processed. A copy of this form should be kept in the patient's chart.
Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

MEMBER INFORMATION

Patient Name:_____ Gender: ☐ M / ☐ F Date of Birth:_____

Patient's Address:_____

Street ☐ ☐ City Zip ☐ Phone

Health Plan: Anthem Blue Cross HMO/POS - Blue Shield HMO - Blue Lake Rancheria - Trinidad Rancheria – North coast Co-op

Member's Primary Care Provider:_____ Subscriber #:_____

REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Out of Area Providers only):
Today's Date:	Place of Service:

Type of Request (circle): ☐ Routine Retroactive Date of Service: _____

Primary Diagnosis:	Secondary Diagnosis:
Cataract: ICD-10: _____ ☐ R ☐ L	ICD-10: _____

Requested Service:

- ☐ **CPT: 66820** Discission of secondary membraneous cataract/stab incision **Quantity** _____
- ☐ **CPT: 66821** Discission of secondary membraneous cataract/YAG Laser **Quantity** _____
- ☐ **CPT: 66982** Extracapsular cataract removal with lens implant **Quantity** _____
- ☐ **CPT: 66983** Intracapsular cataract extraction with lens implant **Quantity** _____
- ☐ **CPT: 66984** Extracapsular cataract removal with lens implant **Quantity** _____
- ☐ **CPT: 66985** Insertion of intraocular lens **Quantity** _____

In order to process this request the following medical necessity information must also be provided:

Is functional visual impairment present related to the cataract(s): ☐Yes ☐No

Additional comments:

• Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage. • Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services. • The requesting physician or the member may submit authorization appeals to the IPA Medical Management Department. • This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.