

Humboldt IPA Authorization Request For Initial and Continuing Rehabilitative Services

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.

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: _____ City _____ Zip _____ Phone _____ Health Plan: _____

HMO: Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO

PPO: Blue Lake Rancheria Trinidad Rancheria North coast Co-op

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

REQUESTING PROVIDER INFORMATION

PROPOSED PROVIDER & FACILITY INFORMATION

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Contact Name: _____ Tax ID # (Out of Area Providers only): _____

Request Date: _____ Place of Service: Office

REQUEST FOR INITIAL AND CONTINUING REHABILITATIVE SERVICES – INCLUDE INITIAL EVALUATION

Diagnosis: _____ ICD10 _____


Initial Tx date _____ Total # visits to date _____

Please answer the following questions with specific details. A legible progress note addressing these topics is an acceptable substitute.

What is the Rehab potential for this patient? List initial pain intensity and significant functional limitations.

If requesting continuing therapy:

What is the expected course of recovery? Where is the member on that spectrum? Please be specific regarding functional progress, pain, etc.

Initial  Goal

Are there barriers to further progress/reasons goals not yet met?

Has the member been compliant with HEP and engaged in treatment? Y N Comment: _____

REQUEST: _____ Visits/Week x _____ Weeks = _____ Total Visits CPT Codes: _____

Provider Name: _____ Provider Signature: _____

Requested by: _____

- Approved authorizations are effective from the date they are received and expire in three (3) months. Authorizations are based on the member's current 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.

CONFIDENTIAL INFORMATION

This facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.