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:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	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 ☐ ☐ 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.