SHARP HEALTH PLAN
make life better.

Medicare Advantage

Prior Authorization Request Form

Incomplete forms will be returned

FAX Completed Prior Authorization Requests to (858) 636-2426

THIS FORM IS FOR SHARP MEDICARE ADVANTAGE MEMBERS

MEMBER NAME – LAST, FIRST, MIDDLE INITIAL	Is this a member request? Yes ☐ No ☐	DATE OF BIRTH	HEALTH PLAN ID NUMBER
MEMBER ADDRESS – STREET, CITY, ZIP CODE			PATIENT TELEPHONE NO.
REQUESTING PROVIDER ☐ PCP ☐ SPECIALIST		TELEPHONE ( )	**FAX (MUST HAVE FOR FAX BACK)** ( )
PCP (IF NOT LISTED BELOW)		DATE PREPARED	PREPARED BY / ELIG CHECKED ☐ yes ☐ no

☐ **Routine/Standard Request:** Decisions will be rendered within (14) fourteen calendar days from receipt by Sharp Health Plan.
☐ **Urgent Request:** Decisions will be rendered within 72 hours from receipt by Sharp Health Plan.

PROVIDER/SERVICE REQUESTED	PROVIDER NAME	EXPECTED DATE OF SERVICE
PROVIDER ADDRESS – STREET, CITY, ZIP CODE	PHONE ( )	FAX ( )
☐ Inpatient ☐ Outpatient	FACILITY NAME	INPATIENT GOAL LENGTH OF STAY

DIAGNOSIS	ICD-10 CODE	PROCEDURES/ EQUIPMENT	CPT CODE	COMMENTS

REASON FOR REQUEST (INCLUDE ALL PERTINENT DOCUMENTATION)

Payment for services is dependent upon the Patient's eligibility at the time services are rendered. Provider please call Health Plan for benefits and eligibility for each visit. Prior authorization valid for ninety (90) days from date approved by Sharp Health Plan.

IMPORTANT ⇨

*** FAX completed Prior Authorization requests (858) 636-2426.**
*** Eligibility Interactive Voice Response (IVR) at 1-800-359-2002, Option 1.**
*** Please submit clinical documentation to support the authorization request.**

FOR SHP UM USE ONLY

☐ **Approved**	**REFERRAL NUMBER**	**DATE RANGE AUTHORIZED**	INITIALS	DATE
☐ **Pended For Additional Information**			INITIALS	DATE
☐ **Denied** ☐ **Member Denial Letter Mailed**			INITIALS	DATE

COMMENTS

 Rev. 4/14

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