

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 <input type="checkbox"/> No <input type="checkbox"/>	DATE OF BIRTH	HEALTH PLAN ID NUMBER
MEMBER ADDRESS – STREET, CITY, ZIP CODE			PATIENT TELEPHONE NO.
REQUESTING PROVIDER <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST	TELEPHONE ()	FAX (MUST HAVE FOR FAX BACK) ()	
PCP (IF NOT LISTED BELOW)	DATE PREPARED	PREPARED BY	ELIG CHECKED <input type="checkbox"/> yes <input type="checkbox"/> 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 ()
<input type="checkbox"/> Inpatient <input type="checkbox"/> 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	<ul style="list-style-type: none"> * 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.
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FOR SHP UM USE ONLY				
<input type="checkbox"/> Approved	REFERRAL NUMBER	DATE RANGE AUTHORIZED	INITIALS	DATE
<input type="checkbox"/> Pended For Additional Information			INITIALS	DATE
<input type="checkbox"/> Denied	<input type="checkbox"/> Member Denial Letter Mailed			DATE

COMMENTS

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender. Rev. 4/14