



Health Net

Request for Prior Authorization For Health Net of California

Instructions: Use this form to request prior authorization for Healthy Families, Healthy Kids & Medi-Cal.

Type or print; complete all sections. Attach sufficient clinical information to support medical necessity for services or your request may be delayed. Fax the completed form to the Health Net Prior Authorization Department at (800) 743-1655. To check the status of your request, call (800) 421-8578, (800) 628-2705 or (800) 642-4746.

MEMBER INFORMATION

Member Name: Last	First	M	Date of Birth (Mo/Day/Yr)
Subscriber #			

Check appropriate box.

Other Insurance/Policy #	Product: <input type="checkbox"/> Healthy Families <input type="checkbox"/> Healthy Kids <input type="checkbox"/> Medi-Cal
<input type="checkbox"/> Work-related	<input type="checkbox"/> Auto accident CCS-Eligible Condition: Yes <input type="checkbox"/> No <input type="checkbox"/>

Designate type of request. Check appropriate box(es)

- Urgent for acute conditions requiring care within 72 hours or less Elective for routine, non-urgent services
- Notification only, for dialysis or prenatal maternity care
- Confidential request: Member/Provider requests confidentiality. Health Net will not mail service-confirmation letter to member.

Designate service requested. Check appropriate box.

- Office procedure
- Outpatient service/surgery
- Inpatient admission
- Orthotics and prosthetics

Anticipated date of service: _____

- DME
- Diagnostic test
- Home health services
- Other _____

PROVIDER INFORMATION

From			To - Where will member receive services?	
First and last name of requesting provider			Name of hospital or provider of services/product (no abbreviations)	
Address			Tax ID # of above	National Provider Identifier of above
City/State/ZIP			Address	
Area Code	Telephone # + OPTIONS and/or EXT.	Fax #	City/State/ZIP	
Contact person (REQUIRED)			Area Code	Telephone # of above + OPTIONS and/or EXT.
Name of primary care physician (PCP) (if applicable)			Assistant surgeon required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Name _____	
Area Code	Telephone # + OPTIONS and/or EXT.	Fax #	Anesthesiologist required? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CLINICAL INFORMATION

ICD-9 code(s) (REQUIRED)	Diagnosis description	Date of onset/injury
CPT/HCPC code(s) (REQUIRED)	# of visits	Describe service requested (Note: Billed CPT codes not approved require clinical review upon submission of claim and report)
Why is the service necessary? (Attach diagnostics, X-rays reports, progress notes, results of conservative treatment)		

Signature of requesting physician	Date
<p>Note: Provider agrees that the results of the care or treatment rendered under this authorization shall be forwarded to the requesting physician or primary care physician named above for inclusion in the patient medical record. Provider agrees to accept Health Net's payment as payment in full and will not bill the member for any amount for services rendered hereunder except for member copayments, deductibles, and co-insurances required under the member's plan. This form is not a guarantee of payment. Charges for services rendered to patients whose coverage is no longer in effect are the patient's responsibility. Eligibility and benefits must be verified before rendering any medical services at www.healthnet.com.</p>	

Health Net Determination

Services approved	Authorization number	Valid date range of authorization	Decision date