Stanford HEALTH CARE ADVANTAGE

PO Box 71210, Oakland, CA 94612
Member Services: 855-996-8422
Provider Services: 855-986-8422
Fax: 510-662-3492

Medical Prior Authorization Request Form

Please check type of request: ❑ Routine (Non-urgent services) ❑ Expedited (Care required within 24 hours —must meet Medicare expedited criteria) ❑ Submission of additional clinical information (include reference #)

Patient Name:	DOB:	Daytime Phone:	
Health Plan:	Health Plan ID#:		
Address:	City:	State:	Zip:
Facility/Provider/Service Information: REQUIRED (ALL)			
Referring Provider:	❑ PCP ❑ SPEC	Phone: (REQUIRED)	
Provider Signature:	Date:	Fax:	
❑ Office ❑ Outpatient ❑ Inpatient Admit ❑ Diagnostics ❑ DME ❑ Home Health ❑ Injectables ❑ Other ____________			
Requested Provider/Facility:	**Requested Physician/Specialist:**		
Name:	First Name:	Last Name:	
Address:	Phone:	Fax:	
Requested Service(s):	**REQUIRED:** ICD-10 Code(s): CPT Codes(s)		
Diagnosis/Clinical Problem: Clinical History/Date of Onset: Prior Treatment: Relevant Diagnostic Testing:			

Form Submitted by: ____ Date _____________________ Phone: _____________________________

THIS AUTHORIZATION IS BASED ON ELIGIBILITY AT TIME THE SERVICES ARE RENDERED.

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