Stanford
HEALTH CARE ADVANTAGE

PO Box 71210, Oakland, CA 94612
Member Services: 855-996-8422
Provider Services: 844-986-8422
Fax: 855-220-1423

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.