Health Net's Request for Prior Authorization

Instructions: Use this form to request prior authorization for HMO, Medicare Advantage, POS, PPO, EPO, Flex Net, Cal MediConnect. This form is **NOT** for Health Net California Medi-Cal or Arizona Access**. Type** or **print;** complete all sections.

Attach sufficient clinical information to support medical necessity for services or your request may be delayed.

Health Net will provide notification of decision by phone, mail, fax or other means.

Washington-Requests for Immediate review (any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of the provider, result in an imminent emergency room visit or hospital admission and deterioration of the member's health status) need to be requested by calling into (888) 802-7001.

Submit Prior Auth Request to: (Please Check One)

- ☐ **Arizona DME Fax Request: DME (800) 916-8996**
- ☐ **Arizona General PA: (800) 840-1097**
- ☐ **California Request: Fax (800) 793-4473 or (800) 672-2135**
- ☐ **Oregon/WA Medicare Request: Fax (866) 295-8562**
- ☐ **Oregon/WA Commercial Request: Fax (800) 495-1148**

MEMBER INFORMATION

Member Name: Last First MI Date of Birth (Mo/Day/Yr) _____

Subscriber # _____

Check appropriate box.

Product: ☐ HMO (POS tier 1) ☐ PPO (POS tier 2) ☐ Out-of-Network (POS tier 3) ☐ EPO ☐ Medicare Advantage ☐ Flex Net
☐ Cal MediConnect Other Insurance/Policy # _____ ☐ Work-related ☐ Auto accident

Designate type of request. Check appropriate box(es).

- ☐ Elective for routine, non-urgent services
- ☐ Expedited/Urgent - Urgent: Needed urgently, if not, could seriously jeopardize the life/health or ability of member to regain maximum function or, in your opinion, would subject member to severe pain that cannot be adequately managed without the Service/Treatment requested below. Explain Clinical Necessity for Urgent/Expedited Request _____
- ☐ Notification only, for dialysis or prenatal maternity care EDC_____
- ☐ Confidential request: Member/Provider requests confidentiality. Health Net will not mail service-confirmation letter to member
- ☐ Post Service Request (Not applicable for Medicare Advantage plans)

Designate service requested. Check appropriate box.

- ☐ Office procedure
- ☐ Outpatient service/surgery
- ☐ Inpatient Services
- ☐ Orthotics and/or prosthetics
- ☐ Clinical Trial
- ☐ Other_____

Anticipated date of service: _____

- ☐ DME
- ☐ Diagnostic/Advanced Radiology CT MRI/MRA PET SPECT
- ☐ Initial Outpatient Rehabilitative____/Habilitative____Services (PT,OT,ST)
- ☐ Initial Home Health - Is Member Home bound? Yes ☐ No ☐
- ☐ Continued Outpatient Rehabilitative___/Habilitative___Services (HH/PT/OT/ST) - Remaining Authorized Visits? ____ Does plan have volume limits?_____

Has member used or will use their last visit within next 24 hours? Yes ☐ No ☐

PROVIDER INFORMATION

Requesting/Ordering Provider Information			**Servicing Provider – Where will member receive services?**	
First and last name of requesting provider	Tax ID/NPI		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 # + EXT.	Fax #	City/State/ZIP	
Requesting/Ordering Contact Name (REQUIRED)	Telephone # + EXT		Area Code	Telephone # of above + EXT.
Name of primary care physician (PCP) (if applicable)			Assistant surgeon required? ☐ Yes ☐ No Name	Tax ID/NPI
Area Code	Telephone # + EXT.	Fax #	Anesthesiologist required? Yes ☐ No ☐	

CLINICAL INFORMATION

ICD-10 code(s) (REQUIRED)	Diagnosis description		Date of onset/injury
CPT 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)			
Is the member terminally Ill? (Life expectancy less than 6 months) ☐ Yes ☐ No ☐ N/A Is the member aware? Yes ☐ No ☐ N/A ☐			
Signature of requesting physician			Date

Note: Provider agrees that the results of the care or treatment rendered under approved authorization shall be forwarded to the requesting physician or primary care physician named above for inclusion in the patient's medical record. Health Net uses evidence-based information and national guidelines to make authorization decisions. Contracted 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 co-payments, 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. Patient eligibility and covered benefits must be verified before rendering any medical services at www.healthnet.com.

PPG USE ONLY- (for use only by delegated groups for HMO members) Do not use for FFS or PPO membership

PG UM Dept **Original** received: Date: Time: Type: ☐ Expedited ☐ Routine	Reason sent to Health Net: ☐ OON ☐Investigational/Experimental ☐ Other: _____	Pended: ☐Yes ☐ No If yes, attach pend letter.	Date add'l info rec'd: