Pre-Authorization Request Form

SAN FRANCISCO HEALTH PLAN™
Here for you

Fax: **(415) 357-1292**
Telephone: **(415) 547-7818 ext.7080**

NOTE: All fields marked with an asterisk (*) are required.

Select all that apply: ☐ New Request ☐ Modification Request for Authorization #: ☐ Second Opinion

Select type of request*: ☐ Urgent ☐ Routine ☐ Retro (Must be submitted within 30 calendar days of date of service)

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Please verify eligibility using one of the following methods:

1. Web: **www.sfhp.org/providers**
2. Interactive Voice Response: **(415) 547-7810**
3. SFHP Customer Services: **(800) 288-5555**

Select line of business: ☐ Medi-Cal ☐ Healthy Kids ☐ Healthy Workers

Does additional coverage exist?* ☐ Yes ☐ No If yes, specify the following: Carrier Policy#

PATIENT	REQUESTING PROVIDER
Name*:	☐ Primary Care Provider ☐ Specialist ☐ Vendor/Ancillary
SFHP ID#: Date of Birth*:	Name*:
Gender: ☐ Male ☐ Female ☐ Other:	Telephone*:
Telephone:	**Contact Name:** Fax:
Address:	Address:
City: State: Zip:	City: State: Zip:

RENDERING PROVIDER

Name / Facility / Vendor*:	☐ Out of Member's Medical Group ☐ Non-Contracted
Specialty*: NPI#:	Reason for out of medical group/non-contracted provider:
Telephone*:	
Contact Name: Fax*:	
Address:	
City: State: Zip:	

DIAGNOSES / SERVICE CODES

At least one valid diagnosis code ***and*** one valid service code are required.*

Diagnosis Codes Please document diagnosis completely.

Service Codes Indicate quantity and modifiers (if applicable) for each code. If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS values.

Code	Mod	Qty	Description	Code	Mod	Qty	Description

Select hospital status*: ☐ Inpatient, number of days: ☐ Outpatient **Date of Service:**

Comments: Today's Date:

Important: Please attach appropriate clinical documentation to support your request.