Valley Health Plan

AUTHORIZATION REQUEST

Instructions: This form is required for authorization of services. Please complete all the **unshaded** sections on this form and fax to the Utilization Management Department at Valley Health Plan.

Fax #: 408.885.4875
Phone #: 408.885.4647

Section 1: **Patient Information**

First Name: _____ Last Name: _____

Date of Birth: _____ Sex (check one): ☐ Female ☐ Male

Address: _____

Phone: _____ VMC Medical Record #: _____

Health Plan ID#: _____

Diagnosis: _____ ICD10 Code: _____

Section 2:

Location of Authorization
☐ Inpatient ☐ Outpatient
☐ Other_____

Request Type (Check One)
☐ Emergency ☐ Routine
☐ Urgent ☐ Retro

Program/Line of Business (Check One)
☐ Employer Group Plan ☐ SCFHP Medi-Cal
☐ Covered CA/Individual & Family ☐ SCFHP HK

Requested Provider

Provider Name: _____

Location: _____

_____

Phone: _____ Fax: _____

Services and Provider Requested

***Section 3*:**

Attach supporting documents such as progress notes, consultation notes, operative/radiological reports, and/or prescriptions to avoid delay in processing request

CPT4 or HCPC	Quantity	Length of Need	Specific Services Requested
1.			
Medical Justification for Request			
2.			
Medical Justification for Request			
3.			
Medical Justification for Request			
4.			
Medical Justification for Request			

Section 4

Requesting Provider: _____ MD Signature: _____ Date: _____

NOTE TO ALL PROVIDERS: This authorization is valid only if the patient is eligible on the date of service. Please recheck eligibility prior to delivering service (VHP Commericial patients: 408.885.4760 or 1.888.421.8444 – Medi-Cal Managed Care, Healthy Kids & Healthy Families patients: 1.800.260.2055).

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AUTHORIZATION REQUEST

Instructions for Completing the Authorization Form

Field Name	Description
SECTION 1 – This section is completed by the requesting physician to provide information about the patient	
Patient Name	Enter the patient's name (first name followed by last name) for whom services are requested
Date of Birth	Enter the patient's date of birth
Sex	Check the appropriate box for the patient's gender
Address	Enter the patient's current address
Phone	Enter the patient's current phone number
VMC Medical Record #	Enter the patient's Medi-Cal number, VMC number, or Social Security number (if Commercial).
Health Plan ID #	
Diagnosis.	Enter the patient's diagnosis or ICD10 Code.
ICD10 Code	
Section 2 – This section is completed by the requesting physician to provide information about the services ordered for the patient.	
Location	Check the appropriate box for the location of the services: INPATIENT, OUTPATIENT, OTHER (Please specifiy)
Type Service	Check the appropriate box for the type of service required: EMERGENCY, URGENT, ROUTINE, or RETROSPECTIVE.
Program/Line of Business	Check the type of program in which the member is enrolled: Employer Group, Covered CA/Individual & Family, SCFHP Medi-Cal, SCFHP HK.
Requested Provider	Enter the information (Name, Location, Phone #, and Fax #) of the requested provider that the referring physician is recommending
Section 3 – This section is completed by the requesting physician to indicate the services required.	
CPT4 or HCPC	Enter the appropriate CPT4 or HCPC code for the procedure requested
Quantity	Enter the number of procedures/treatments requested
Length of Need	Enter the amount of time the procedure/treatment is required
Specific Services Requested	Enter the specific information regarding the services required
Medical Justification for Request	Enter the medical information to indicate the need for the procedure/treatment
Section 4 – This section is completed by the requesting provider.	
Requesting Provider	Print the name of the requesting provider
Signature	The requesting provider must sign the treatment authorization request.
Date	Indicate the date when the requesting provider signs the request.