Hospital Review Priority / Type of Clinical Service Requested

Fax to L.A. Care Health Plan: (877) 314–4957 Main Phone Number: (877) 431-2273

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE

Do not schedule non-emergent services until authorization is obtained

Facility Admission and Concurrent Review Request Fax: 213-438-5063

☐ Acute Inpatient Initial Authorization Request *Facility Face Sheet* *+ Clinical Records Supporting Medical Necessity* *+ Discharge Plan* ☐ Acute Inpatient Continued Stay Authorization Request *Clinical Records Supporting Medical Necessity* *+ Discharge Plan*	☐ Administrative Days Request *Acute Inpatient Authorization Number:* *Dates of Service Requesting Administrative Days For:* (MM/DD/YY): / / *Clinical Records Including Documentation of Discharge Plan and Efforts Being Made to Discharge*	☐ Retro Review – Post Discharge *Facility Face Sheet* *+ Clinical Records Supporting Medical Necessity* *+ Discharge Summary*
☐ **Emergent Higher Level of Care (Initial)** Or Call Main Phone Number (877) 431 – 2273 and follow prompts	☐ **Transfer Request** Or Call Main Phone Number (877) 431 – 2273 and follow prompts	☐ **Higher Level of Care (Concurrent Review)**
Facility Face Sheet *+ All Clinical Records* *+ Detailed Data Supporting Higher Level of Care* **Fax: 213-438-2204**	*All Clinical Records* *+ Detailed Clinical Documentation Supporting Reason for Transfer Request* **Fax: 213-438-2204**	*All Clinical Records* *+ Clinical Records Supporting Continued Medical Necessity* *+ Discharge Plan* **Fax: 213-438-2204**

Discharge Planning Notification or Discharge Orders / Plans Fax: 213-438-5066 *Attachments are REQUIRED if Discharging Member				**Difficult Placement Assistance Fax: 213-438-5095**
☐ LTACH	☐ HH	☐ ARU	☐ DME	
☐ SNF Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ LTC-SubAcute Adults ☐ LTC-SubAcute Pediatrics ☐ LTC-Custodial *PASRR Level 1 Screening Results: ☐ Positive for SMI or ID/DD/RC ☐ Negative *PASRR Level 2 Screening Results: ☐ Positive ☐ Negative *Screening Completed? ☐ Yes ☐ No *Date of Screening: *PASRR CID: ***We cannot process your request without PASRR results**				SNF Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ LTC- SubAcute Adults ☐ LTC-SubAcute Pediatrics ☐ LTC-Custodial *Detailed Placement Attempt* *List of Barriers* *Current Referral Packet to be Included* *See Difficult Auth Request Form and Checklist*
☐ Expected Discharge Date (MM/DD/YY): / /		☐ Discharge Orders Attached		
☐ Actual Discharge Date (MM/DD/YY): / /		☐ Discharge Plan Attached		

***Member Name:**		
***Member ID:**	***Date of Birth:**	
***Requesting Provider:**		***Specialty:**
***Request Date:**	***Request Type:**	
***Phone Number:**	***Fax Number:**	***NPI:**
***Address:**	***City:**	***Zip:**
To find an in-network Provider please visit http://www.lacare.org/find-doctor-or-hospital		
***Date(s) of Service (Anticipated Admit Date or Admission Date through Discharge Date if applicable):**		
***Servicing Provider:**		***Specialty:**
***Phone Number:**	***Fax Number:**	***NPI:**
***Address:**	***City:**	***Zip:**
***Place / Type of Service: ☐ LTAC ☐ ARU ☐ SNF ☐ HH ☐ DME**		
***Servicing Facility (if applicable):**		
***Phone Number:**	***Fax Number:**	***NPI:**
***Address:**	***City:**	***Zip:**
***List ICD-10 Codes below: Level of Care / CPT / HCPCS Codes / Descriptions for service(s) REQUIRING Authorization**		
***Clinical Indications (Include pertinent past medical treatment, physical findings and attach all relevant medical records, test results, etc.)**		
Is the service being requested Out of Network? ☐ *No* ☐ *Yes* If yes, please provide reason for using an Out of Network facility/provider:		
Print Requesting Provider Name:	Provider Signature:	Date:

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