AAMG
Your choice. Your health. Our mission.

AUTHORIZATION REQUEST FORM (ARF)

☐ **ROUTINE Fax to (888) 744-8665** ☐ **RETRO Fax to (888) 744-8665**

☐ **URGENT REQUEST Fax to (833) 964-0916**

*****Definition: "Urgent" is ONLY when normal time frame for authorization could seriously jeopardize the life, health and safety of the member or others, due to the member's psychological state, OR in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. *****

*****IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered.

Patient Last Name: ______________________ First Name: ______________________ ☐ M ☐ F DOB__________

Patient Address: ____________________________________ City: ______________________ Zip: ________________

Health Plan ID#: ____________________________________ Patient Phone #: ______________________________

Contracted Health Plans:

☐ Aetna HMO	☐ Brand New Day Medicare Advantage
☐ Anthem Commercial HMO	☐ Brand New Day Medi-Medi D-SNP
☐ Anthem Medi-Cal HMO	☐ Health Net Commercial HMO
☐ Anthem Medicare Advantage	☐ San Francisco Health Plan
☐ Anthem Medi-Medi D-SNP	☐ Wellcare by Health Net Medicare Advantage
☐ Blue Shield of California HMO	☐ Wellcare by Health Net Medi-Medi D-SNP

PROVIDER INFORMATION

Requesting/Current Provider:	Provider/Facility/Vendor Requested for Service:
Provider NPI:	Provider NPI:
Provider Address: Phone:______________ Fax:________________	Provider Address: Phone:______________ Fax:________________
Office Contact: Physician Signature:____________________________	Office Contact:

AUTHORIZATION REQUEST

Type of service:	List ALL diagnoses and procedures requested along with appropriate CPT/HCPCS		
	ICD-10 & Diagnosis	Service (CPT or HCPCS)	Quantity (Required)
☐ **Office Visit/Procedure**	______________________	________________	__________
☐ **DME**	______________________	________________	__________
☐ **Home Health**	______________________	________________	__________
☐ **Inpatient Procedure**	______________________	________________	__________
☐ **Inpatient Admission**	______________________	________________	__________
☐ **Outpatient Procedure**			
☐ **Skilled Nursing Facility**			

Medical History and Justification (if additional space is needed, attach supporting medical records):

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