



P.O. BOX 11033 ORANGE, CA 92856

Phone: 855-877-3885

# Behavioral Health-Authorization Request Form (BH-ARF)

ROUTINE

Behavioral Health Fax: 714-571-2462

\*\*\* IN ORDER TO PROCESS YOUR REQUEST, BH-ARF MUST BE COMPLETE AND LEGIBLE \*\*\*

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

### MEMBER INFORMATION

Member Name (Last, First):			Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:		
Age:	DOB:	Client Index # (CIN):		ICD-10 Dx:	
Mailing Address					Phone:
Program (select one only): <input type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare <input type="checkbox"/> OneCare Connect					

### REFERRING PROVIDER INFORMATION

### RENDERING PROVIDER INFORMATION (If different from referring provider)

Name:			Name:		
NPI:		Medi-Cal ID:		NPI:	
TIN:		Phone:	Fax:		TIN:
Address:			Address:		
Office Contact:			Office Contact:		
Provider's Signature:					

### AUTHORIZATION REQUEST

URGENT REQUEST Fax to 714-481-6453. \*\*\*Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.\*\*\*

List ALL procedures requested, along with the appropriate CPT/HCPCS. Supporting documentation to include:

- Psychological Testing Request Form (For psych testing only)
- Clinical records to support request

REQUESTED PROCEDURES	CODE (CPT or HCPCS)	UNITS AND DURATION