OneCare Connect
CalOptima
A Public Agency
Better. Together.

Cal MediConnect Plan (Medicare-Medicaid Plan)

P.O. BOX 11033 ORANGE, CA 92856 **Phone: 714- 246-8686**

AUTHORIZATION REQUEST FORM (ARF)

☐ **ROUTINE** ☐ **RETRO** **OneCare Connect Fax 714-571-2440**

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

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

Patient Name: _____ ☐ **M** ☐ **F** **D.O.B.** _____ **Age:** _____
Last First

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Client Index # (CIN): _____

Referring Provider:	**Provider Rendering Service (Physician, Facility, Vendor):**
Provider NPI#: _____ **TIN#:** _____ **Medi-Cal ID#:** _____	**Provider NPI#:** _____ **TIN#:** _____ **Medi-Cal ID#:** _____
Address: **Phone:** _____ **Fax:** _____	**Address:** **Phone:** _____ **Fax:** _____
Office Contact: _____ **Physician's Signature:** _____	**Office Contact:** _____
Diagnosis: _____	**ICD-10:** _____

AUTHORIZATION REQUEST

☐ **URGENT REQUEST Fax to 714-571-2440. ***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.*****

☐ **Inpatient Facility** ☐**Outpatient Facility** ☐ **SNF:**

Retro Date(s) of Service _____

List ALL procedures requested along with the appropriate CPT/HCPCS and Supporting Documentation

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

Revised 2/15/2017