REQUEST FOR LETTER OF AGREEMENT

CalOptima UM Department Fax: **714-796-6654**

Sections 1 through 4 must be fully completed for request to be processed. If a section does not apply, insert "N/A."
INCOMPLETE REQUESTS WILL BE RETURNED.

SECTION 1 — Responsible Contact Submitting LOA Request

Request Date:

Requested Provider Pre-LOA Quality Check Completed Date: (i.e., OIG, SAM, S&I, Medicare Opt-Out) Pass/Fail:

Requestor Name/Title: Phone: Email:

SECTION 2 — Member Information

Last Name: First Name: Middle Initial:

Health Network: Effective Date with Health Network:

CIN #: DOB: MSSP #:

Program: ☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ MSSP ☐ PACE

SECTION 3 — Requested Provider for LOA Service (Must Pass Quality Check)

Provider Legal Name: dba Name:

TIN: NPI: NPI Level 1 ☐ or NPI Level 2 ☐

Contact Name/Title: Phone: Fax or Email:

Service Location Address:

Provider Type: ☐ Hospital ☐ ASC ☐ SNF (Skilled/Short stay) Level of Care: _____ ☐ LTC NF

☐ Professional (list specialty): ☐ Behavioral Health (list specialty):
☐ Ancillary (list type): ☐ Other:

SECTION 4 — Requested LOA Service

Authorization #: Authorization Effective Date:

LTC DOS Begin Date: LTC Discharge Date:

Expected DOS Beginning (Prospective Admit): ☐ Outpatient ☐ Inpatient

Description of Authorized Service(s) including CPT/HCPCS Codes # of units:

Type of Transplant: _____
☐ Evaluation ☐ Pre-Care ☐ Transplant Event
☐ Post-Care Date of Transplant: _____

☐ Continuity of Care

Reason for Referral to a non-contracted provider/Comments:

FOR CALOPTIMA USE ONLY

CalOptima Medical Director / Department Director / Designee Signature for Approval

Signature/Title: Date:

FOR CONTRACTING DEPARTMENT USE ONLY

Approved by Director of Contracting or Designee: Date:

STOP

INCOMPLETE REQUESTS WILL BE RETURNED AND NOT PROCESSED UNTIL FULLY COMPLETED.