P.O. Box 8350
La Verne, CA 91750

Phone: (888) 293-6383
Fax (Auths): (833) 813-7600
Fax (Inpatient Auths): (888) 320-3851

Request Date: _____

RETROSPECTIVE AUTHORIZATION REQUEST FORM (RARF)

Patient Name (Last, First): _____ ☐ Male ☐ Female
DOB: _____ Age: _____
Patient Mailing Address: _____ City: _____ Zip: _____
Patient Phone: _____ Member ID & Health Plan: _____

Requesting Provider Name:	Servicing/Requested Provider:
Provider NPI #:	Provider NPI #:
Provider TIN #:	Provider TIN #:
Address: Phone:	Address: Phone:
Fax:	Fax:
Office Contact Name & Role:	Office Contact Name & Role:

Servicing/Requested Facility (if applicable): _____
Facility NPI #: _____ Facility TIN #: _____ Address: _____
Phone: _____ Fax: _____ Office Contact Name & Role: _____

Diagnosis: _____ ICD-10: _____

Notice to Provider: Authorization does not guarantee payment, ELIGIBILITY must be verified prior to services rendered.

RETROSPECTIVE AUTHORIZATION REQUEST

IN ORDER TO PROCESS YOUR REQUEST, THIS FORM MUST BE COMPLETED AND LEGIBLE

☐ Inpatient Facility ☐ Office ☐ Surgery Center / Outpatient ☐ Physician Administered / Part B Drugs
☐ SNF ☐ Medical Services/Items

Date(s) of Service: _____

Inpatient Admission Date (if applicable): _____

List ALL procedures requested along with the appropriate CPT/HCPCs and **submit supporting Medical Records.**

Requested Procedures	Code (CPT or HCPC)	Modifiers	Units (Required)
1.			
2.			
3.			
4.			

You **MUST** indicate in the below space the specific reason and supply evidence/medical records as to why the above services were provided without first getting prior authorization approval as required.