P.O. Box 8350
La Verne, CA 91750

NeueHealth

Phone: (888) 293-6383

AUTHORIZATION REQUEST FORM (ARF)

IPA Name:

☐ ROUTINE Fax to (888) 320-3851 ☐ ADMISSION Notification Fax to (888) 320-3851

***** 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 Name: ______________________________ ☐ M ☐ F D.O.B. ______________ Age: ______________
Last First

Mailing Address: ______________________________ City: ____________________ ZIP: __________ Phone: ______________

Member ID : ______________________ Name of Facility (if applicable): ______________________________

Requesting Provider:	Servicing Provider (Physician, Facility, Vendor):
Provider NPI# ______________ Provider TIN#: ______________	Provider NPI#: ______________ Provider TIN#: ______________
Address: ______________ Phone: ______________ ______________ Fax: ______________	Address: ______________ Phone: ______________ ______________ Fax: ______________
Office Contact: ______________________________	Office Contact: ______________________________
Diagnosis: ______________________________	ICD-10: ______________________________

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to (888)-320-3851. ***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 Requests	SNF	Medical Services/Items	Part B Drugs

Date of Services: ______________________________ Admission Date: ______________________________

List ALL procedures requested along with the appropriate CPT/HCPCS

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

DO NOT WRITE BELOW THIS LINE

STATUS		Authorization Number #:	
☐ Approved	☐ Alternative Treatment	Signature:	Date:
☐ Not a Covered Benefit	☐ Modified	Comments:	
☐ Not Medically Indicated		Phone:	