

LONG TERM CARE (LTC) AUTHORIZATION REQUEST

☐ ROUTINE

☐ URGENT

☐ RETROACTIVE

I. PATIENT INFORMATION

PRIMARY LANGUAGE SPOKEN: _____
Require Interpreter: ☐ Y ☐ N ☐ American Sign Language

Member Name: _____ DOB: _____ Gender: ☐ F ☐ M

Member Address: _____ City: _____ Zip: _____

Phone #: _____ Member ID #: _____ ☐ Medicare ☐ Medi-Cal

II.

Date of Request: _____ Requesting Physician: _____

III. SERVICE(S) REQUESTED (Use ICD-10 Codes for Date of Request on or after 10/01/2015)

☐ Home Health ☐ Infusion ☐ Transportation ☐ DME ☐ Medical Supplies
☐ Respiratory Supplies ☐ Hospice ☐ Enteral Feedings ☐ Decubitus Equipment ☐ Other

Diagnosis: _____ ICD-10 code(s): _____

Service(s)/Procedure(s): _____ CPT code(s): _____

Prior Treatment & Results: _____

Physician's Signature: _____ Fax: _____
(May attach MD ORDER)

Phone: _____

U.M. Decision Status: ☐ APPROVED ☐ MODIFIED ☐ DEFERRED ☐ DENIAL

AUTH #: _____ Date Approved: _____ Date Auth. Expired: _____

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN USE ONLY:

Member Eligibility as of: _____ PCP Provider ID #: _____

☐ IPA RESPONSIBILITY Date faxed to IPA: _____

THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. CHECK ELIGIBILITY PRIOR TO RENDERING SERVICE. Payment will NOT be made for unauthorized services. All lab and x-rays must be ordered/performed by contracting providers Contact Blue Shield of California Promise Health Plan U.M. Department at above number, if unsure. Specialist reports must be sent to PCP promptly.