Santa Clara Family Health Plan™

Prior Authorization Request Form

Utilization Management

Phone: **1-408-874-1821**

Fax: **1-408-874-1957** or **1-408-376-3548**

Today's Date: _____

Type of Request:

☐ Routine (5 business days) ☐ Expedited (3 business days) ☐ Retro (30 calendar days)

SCFHP MEMBER INFORMATION

Member Name: _____

Date of Birth: _____ **SCFHP ID:** _____

Line of Business: ☐ Medi-Cal ☐ Healthy Kids ☐ Cal MediConnect

REFERRING PROVIDER INFORMATION

Referring MD: _____

Contact Name: _____

Phone: _____ **Fax:** _____

SERVICES(S) REQUESTED*:

*Supporting documentation and physician order MUST accompany request. Failure to provide documentation will delay processing and may result in a denial of services.

Referring to: _____

Phone: _____ **Fax:** _____

Service(s) Requested: _____

CPT/HCPCS: _____ **Diagnosis Code:** _____

Number of units/visits: _____ **Date(s) requested:** _____

Place of Service: ☐ Inpatient ☐ Outpatient ☐ MD Office ☐ Amb Surg

☐ Other (specify): _____

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