San Diego Ryan White Home Health & Hospice Specialty Services Authorization Request

AHF

Instructions

Prior authorizations are required for referrals to specialists participating in the Ryan White Specialty Services Program and all covered medical procedures and services. **. All request must be HIV-related. Providers and facilities must be in network** See the *Provider Information* publication for more information about covered and excluded services. See the *Provider Directory* for network providers.

Authorization Request Instructions:

Complete this form for specialty services authorization requests and fax it to Utilization Management at **(888) 748-1290**. Authorization must be obtained *prior* to completion of services. Routine authorization requests are rendered within two (2) business days. Please call (800) 474-1434, option 2 for authorization status. *Please use the Medical Specialty Request form for Medical specialty referrals, and the Dental Specialty Services Authorization Request form for dental specialty referrals.*

Date of Request:_____ ☐ Medically Expedited/Urgent*

*MEDICALLY EXPEDITED/URGENT REQUESTS: THE DEFINITION OF URGENT/EXPEDITED SERVICE REQUEST DESIGNATION IS WHEN THE TREATMENT REQUESTED IS REQUIRED TO PREVENT SERIOUS DETERIORATION IN THE PATIENT'S HEALTH OR COULD JEOPARDIZE THE PATIENT'S ABILITY TO REGAIN MAXIMUM FUNCTION. REQUESTS OUTSIDE OF THIS DEFINITION SHOULD BE SUBMITTED AS ROUTINE/ NON-URGENT. URGENT/ EXPEDITED REQUESTS THAT DO NOT MEET MEDICAL CRITERIA WILL BE DOWNGRADED TO A STANDARD REQUEST.

Patient Information

_____ _____ Gender: ☐ Male ☐ Female ☐ Transman ☐ Transwoman

Patient Name Birth Date

_____ _____

Phone Number Patient Address

Referring Primary Care Provider Information

_____ _____

Provider Name Clinic Name

_____ _____

Address Provider NPI

_____ _____ _____

Contact Phone Fax

I confirm that I have verified that the above named patient is eligible to receive services under the Ryan White Primary Care Program.

_____ _____

Signature of Clinic Staff Completing Form Print Name and Title of Clinic Staff Completing Form

Indication for Referral

Reason for Referral _____

Diagnosis(es)/ICD-10 Code(s) _____

Requested CPT Codes) _____

_____

List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data _____

_____

Is this request HIV-related? ☐ Definitely ☐ Possibly ☐ Not Related

Explain how the patient's indication is related to HIV? _____

_____

Requested (Refer to) Provider Information

_____ _____ _____

Requested Provider/Facility Name Phone Fax

_____

Specialty