San Diego Ryan White Medical 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 Medical Specialty 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 Home Health and Hospice Authorization Request form for home health and hospice 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

Patient Name ______________________ Birth Date ______________ Gender: ☐ Male ☐ Female ☐ Transman ☐ Transwoman

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 ______________________