KAISER PERMANENTE®

393 E. Walnut Street PE Pasadena, CA 91133 Phone: (866) 551-9619
Complex-Case-Management@kp.org

AUTHORIZATION REQUEST FORM (ARF)

☐**URGENT (72 hr Process) Fax to (877) 515-6591** ☐**ROUTINE Fax to (877) 515-6591** ☐**Retro Fax to (877) 515-6591**

*********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:**_____

Client Index# (CIN:_____ **Name of ICF/SNF (if applicable):**_____

Referring Provider:	**Provider Rendering Service (Physician, Facility, Vendor):**
Provider NPI#:_____ **TIN#:**_____ **Medi-Cal ID#:**_____	**Provider NPI#:**_____ **TIN#:**_____ **Medi-Cal ID#:**_____
Address: **Phone:**_____ **Fax:**_____	**Address:** **Phone:**_____ **Fax:**_____
Office Contact:_____ **Physician Signature:**_____	**Office Contact:** _____
Diagnosis:_____	**ICD-10:**_____

AUTHORIZATION REQUEST

☐**Inpatient Facility** **Estimated Length of Stay:**_____
☐**Outpatient Facility** ☐**SNF:**_____

Date(s) of Services:_____ **Retro Date(s) of Service:**_____

List ALL Procedures requested along with the appropriate CPT/HCPCS

Requested Procedures	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT/HCPCS)	QUANTITY (REQUIRED)

DO NOT WRITE BELOW THIS LINE	FOR KAISER PERMANENTE USE ONLY
STATUS	
☐Approved	Authorization Number #
☐Not a Covered Benefit	Signature:_____ Date:_____
☐Not Medically Indicated	Comments:
☐Alternative Treatment	
☐Modified	
Affiliated Health Plan:_____	Phone:_____